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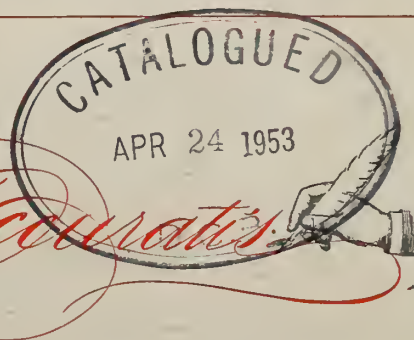
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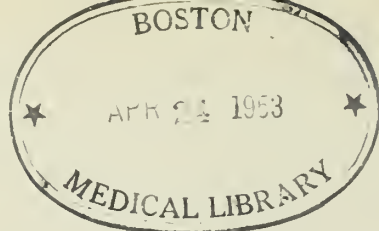
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THE JOURNAL

OF THE

MEDICAL ASSOCIATION OF GEORGIA

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Vol. XL

Atlanta, Georgia, January, 1951

No. 1

THE SIGNIFICANCE AND MANAGEMENT OF CARDIAC ARRHYTHMIA

BRUCE LOGUE, M.D.

Atlanta

The Management of Cardiac Arrhythmias

There is hardly any field of medicine in which the physician at times is not confronted with the control of cardiac arrhythmia, whether this be the psychiatrist plagued by heart consciousness and extrasystoles in his patients, the pediatrician confronted by rapid heart action in infancy or the surgeon disturbed by the sudden onset of rapid heart action or arrhythmia during operation or in the immediate postoperative period. The practicing physician is every day presented with complaints referable to the functioning of the heart. There is no organ in the body which is so susceptible to the emotional content of thought, to anxiety, to tension, to the stresses of every day life. The heart is the traditional seat of the emotions and we speak of a person as being warm hearted, cold hearted, faint hearted, strong hearted, weak hearted, heart sick, heartless, etc. To the layman, the proper functioning of the heart represents life itself; any malfunction of the heart engenders thoughts of sudden death. And yet the average layman does not recognize the impact of fright, nervousness, worry, etc., in the genesis of symptoms referable to the cardiovascular system. And all too often we as physicians overlook the implications of the "skipping heart" and may be prone to ascribe such malfunction

to some underlying disease. I dare say that everyone has extrasystoles at some time or other although in most individuals these do not reach the threshold of consciousness. I have many times observed runs of extrasystoles in patients and by discreet inquiry found that they were not aware of them. On the other hand once the awareness of the heart is kindled by some chance remark of the physician, a sudden death by heart disease in some member of the family or in a friend, or perhaps as the result of being turned down for insurance after an examination, then there may be an acute consciousness of every beat or skip of the heart. An extrasystole now literally shaking the body where before they were unnoticed. Frequently the patient may describe what he is experiencing and yet when he comes to the doctor his rate may be perfectly regular and the doctor may pass off his complaint with the statement that your heart is sound. Frequently this is sufficient to break the vicious cycle but more often this is inadequate. In such circumstances one may precipitate and reproduce the complaints by the discussion of some disturbing life situation or by producing anger or fright. This serves some useful purpose by a concrete demonstration of the nature of the trouble and the factors of importance in its production. It may also be of help in therapy by identifying the type; extrasystoles arising from the auricles or AV node may respond to digitalis, whereas digitalis may increase extrasystoles arising from the ventricles, and here quinidine or pronestyl are the drugs of choice. The premature beat or the compensatory pause which

follows may be responsible for the discomfort.

What does the patient experience when skips occur? He may describe a "flopping over" sensation, a "sinking feeling", a kicking up or pressure sensation in the neck and throat, a sense of fullness or oppression in the chest, a quivering sensation in the region of the heart, a "thud", the heart seems to stop or the extrasystole may be associated with a transient sharp, sticking or stabbing pain. The normal beat after the premature contraction may feel like a strong thump due to the increased stroke volume occasioned by the increased ventricular filling. At times there may be no sensation in the chest and the complaint may be one of dizziness, especially if there are a series of premature beats. He complains of a pulsation or wave reaching to the top of the head. At other times there may be a sense of "indigestion" or "gas on the stomach" which is relieved when the premature beats are controlled. They may cause involuntary deep sighs. With runs of extrasystoles, anxiety, pallor, sweating, nausea, weakness, dizziness, faintness and breathlessness may ensue. Extrasystoles are more liable to occur when the person is at rest or upon lying down at night. In the normal heart they tend to clear up during exercise when the rate is accelerated, shortening the resting period of the heart and thus allowing less opportunity for an ectopic pacemaker to take over. On the contrary, with diseased hearts more premature beats occur during exercise. There may be a flurry of beats in the normal heart immediately after but not during exercise.

Premature systoles may occur at times during a febrile illness and I have been impressed how often they first appear during or following a simple upper respiratory infection. Other precipitating factors in the absence of organic heart disease are periods of emotional tension, fatigue, smoking, alco-

hol, constipation, coffee, anemia, gaseous distension, etc. The premature beats with coupling due to digitalis are well known.

In the management of extrasystoles reassurance may at times result in a lessening of the complaint or at least the threshold of consciousness may be altered so that they are less noticeable. Sedatives such as phenobarbital gr. $\frac{1}{4}$ 3-4 times daily may be effective. If the extrasystoles are frequent and persistent, quinidine in a dose of 3-6 grs. 3-4 times daily may control them. For premature beats arising from the auricles or AV node, complete digitalization may control them. For extrasystoles arising from the ventricles papaverine gr. $1\frac{1}{2}$ every four hours may be useful, particularly in the presence of coronary disease. Potassium salts in a dose of 1 Gm. four times daily may be used and is particularly helpful in the presence of digitalis intoxication. The relief of nervous tension, sufficient rest, relaxation, a trial of omission of smoking, and of such stimulants as tobacco and alcohol are important. In many individuals these measures seem to have little effect but in others they are effective.

I should like to mention sinus arrhythmia which is a normal pulse irregularity in the young and aged. It is usually associated with bradycardia and the pulse speeds up at the end of inspiration. Reflexes from the lung and respiratory center depress the vagus center so that reflex acceleration occurs. It may disappear when the breath is held or with exercise.

Paroxysmal auricular tachycardia is more often unassociated with organic heart disease, although it may be encountered in patients with mitral stenosis, thyrotoxicosis and myocardial infarction. It is usually characterized by a sudden onset and sudden offset of a rapid regular rate. The rate usually varies from 160 to 220. Furthermore the rate remains surprisingly constant from minute to minute. It may be accom-

panied by a sensation of weakness, dizziness, fullness in the neck or a sense of pressure in the epigastrium. On rare occasions coronary insufficiency may occur due to inadequate filling occasioned by the rapid rate. The duration is from a short run of a few beats to a duration of many days. The attacks always begin and end with an extra systole. In general there are two types: 1. A type in which theoretically circus movement passes through the SA node with resulting upright P waves in leads 2 and 3 of the electrocardiogram. 2. A type in which the circus movement passes through the AV node in which case the T waves are inverted in leads 2 and 3. About $\frac{1}{3}$ to $\frac{1}{2}$ of the cases respond to simple vagal stimulations through pressure over the carotid sinus. The vagal reflex may also be elicited by painful pressure over the eyeballs, by prolonged retching or vomiting or by the Valsalva maneuver in which the patient takes a deep breath and strains down with the glottis closed. Vagal stimulation may be produced by retching or vomiting following the administration of 1 to 3 teaspoons of syrup of ipecac or following the administration of morphine or apomorphine. The most satisfactory means of stopping paroxysmal auricular tachycardia is by the intravenous administration of a quick acting digitalis preparation. We have been accustomed to the administration of 1.6 mg. of lanatoside C intravenously. This is usually followed by cessation of the attack within 30 minutes to one hour. At times carotid sinus pressure which was previously ineffective may cause an abrupt cessation of the attack following the administration of such drug. One of the newer treatments is the administration of 1 mg. of neosynephrine intravenously. This acts by elevation of the blood pressure with subsequently stimulation of the carotid sinus and reflex vagal flowing of the heart. Prostigmine in a dose

of 1 mg. may elicit stimulation and stop an attack. Quinidine sulfate may be given in a dose of 6 grs. every two hours until the attack stops. Mecholyl in a dose of 10 to 20 mg. subcutaneously is quite effective but is associated with numerous side reactions and I do not think it is warranted in the average case. Acetylcholine, 50 to 100 mg. i.v., is effective. Magnesium sulfate 20 cc. of 20 per cent solution given slowly intravenously is an effective drug where other measures have failed. Where attacks are frequent complete digitalization may prevent their recurrence. Prophylactic quinidine in a dose of 3 to 6 grs. three to four times daily is useful. The same measures which are helpful in treating premature beats may also be used here.

Paroxysmal tachycardia in infancy may present, with fever, respiratory rates as fast as 100, and a ventricular rate as high as 300. There may be pulmonary congestion and enlargement of the liver. Many of these infants have been diagnosed as pneumonia. They may respond dramatically to the administration of $\frac{1}{2}$ to 1 cat unit of digitalis, to a small dose of quinidine, to neosynephrine. In patients who have an accessory muscle bundle extending from the auricle to the ventricle, the so-called Wolff-Parkinson-White syndrome, there may be repeated attacks of paroxysmal tachycardia. The diagnostic features are demonstrated in the electrocardiogram by the occurrence of a short PR interval less than 0.12 seconds with a prolonged QRS interval giving the so-called false bundle branch block. Attacks may be stopped or prevented by the administration of quinidine.

Paroxysmal auricular fibrillation occurs in the association of mitral stenosis, thyrotoxicosis, coronary disease, hypertension, congenital heart disease with interatrial septal defect, pericardial disease, and pulmonary embolism. Less often this may oc-

cur in a perfectly normal heart. We have seen a number of cases occur during operation and in immediate postoperative periods apparently precipitated by anoxia of anesthesia in addition to vagal reflexes. In the paroxysmal form the treatment of choice is intravenous lanatoside C. The results may be similar to those seen with paroxysmal tachycardia. Where the arrhythmia has been of long standing the preferable treatment is quinidine. Our procedure has been to give 6 to 9 grs. every two hours by mouth from 7:00 A. M. to 7:00 P. M. Frequently the arrhythmia reverts following a single dose. If the patient has repeated attacks they should be kept on prophylactic quinidine. So long as auricular fibrillation is present the danger of dislodging mural thrombi with resultant embolism persists. Studies in a large series of cases show that this risk is no greater with treatment than if the rhythm is allowed to persist. If there is persistent fibrillation no attempt at conversion should be made if there is bundle branch block or AV block. It should be treated if there has been embolism, with the hope that the deposition of auricular thrombi and subsequent dislodgement may be prevented. It should be treated if the ventricular rate can not be controlled by digitalis or if there is persistent heart failure. In an occasional patient, angina pectoris is improved following the onset of fibrillation and it is best not to attempt conversion in these cases. About $\frac{2}{3}$ of the cases of auricular fibrillation may be converted to a sinus mechanism. Unfortunately the rhythm may again recur within a period of weeks or months. In controlling auricular fibrillation by digitalis it is important to remember that the ventricular rate while the patient is ambulatory should be used as a guide. If the dosage of digitalis is inadequate the rate may be normal at rest but may be accelerated during activity.

Auricular flutter is less common than auricular fibrillation but in general has the same connotation. It is more resistant to therapy than auricular fibrillation and causes more subjective symptoms due to marked variability of rate associated with varying degrees of AV block. It may be suspected clinically with rapid rates when there is a varying intensity of the first heart sound, the accentuation occurring when ventricular contraction happens to occur with the AV valves depressed to a great degree. Carotid sinus pressure by increasing AV block may give a prompt but transient slowing of the rate. The treatment of choice is large doses of digitalis which frequently converts the mechanism to auricular fibrillation before returning to a sinus mechanism. Quinidine is helpful in some cases that do not respond to digitalis. The Argentinians have recently discovered a new alkaloid called fagarine which may stop flutter or fibrillation within an hour after a single dose intramuscularly however, there have been a number of deaths due to ventricular fibrillation and its use is still in the experimental stage.

Paroxysmal ventricular tachycardia is only rarely seen in patients with a normal heart. Wilson has reported a type occurring with exertion. It more often occurs in patients with coronary disease, particularly following myocardial infarction. It is more frequent in this situation where digitalis has been administered. It may occur following toxic doses of quinidine and we have seen two patients in whom this developed during administration of a small dose quinidine intravenously. We have also seen a short paroxysm following the administration of neosynephrine intravenously. One should always suspect ventricular tachycardia when the ventricular rate increases rather than slows following the administration of digitalis

and further digitalis should not be given until one is assured that ventricular rhythm has not occurred. We have seen this occur in patients with myocardial infarction during the administration of intravenous aminophylline. The most consistently effective treatment for ventricular tachycardia is Quinidine sulfate which prolongs the refractory period of the muscle in addition to prolonging conduction time. It may be given in a dose of 6 to 9 grs. every two hours by mouth. In the rare instance in which the situation is critical, for example, the patient in shock with myocardial infarction, it should be given slowly intravenously. Preparations of quinidine lactate containing 0.65 Gm. in 10 cc. of solution should be diluted to one to two hundred cc. of glucose solution and given slowly over a period of one hour. Magnesium sulfate, 20 cc. of 20 per cent solution, may at times be effective. A large dose of morphine given intravenously has been reported to result in the cessation of ventricular tachycardia. There have been rare cases in which digitalis by improving cardiac function and presumably coronary flow has resulted in a reversion to a normal sinus mechanism. In general, digitalis is contraindicated in this rhythm since it increases ventricular irritability and may precipitate ventricular fibrillation. Procaine in a dose of 1 Gm. to 1000 cc. of solution has been used with reported success in the treatment of ventricular tachycardia and fibrillation. The chest surgeon feels that it is helpful in preventing arrhythmias when handling of the heart or adjacent structures is necessary. Long and Durant have been unable to corroborate these results in the experimental animal, and have shown that with toxic doses ventricular tachycardia and fibrillation may be produced. (See footnote).

We have observed one patient in which paroxysmal ventricular fibrillation occurred

without clinical evidence of heart disease. Where ventricular fibrillation occurs at the operating table, Beck has used electrical shock with the electrode applied directly on the heart to defibrillate the ventricles. This has been followed by the administration of adrenalin and the return to a normal sinus mechanism. Where cardiac standstill occurs during operation it is imperative that within a few minutes cardiac massage be begun manually either by an approach through the diaphragm or through the thoracic space; 100 per cent oxygen should be given through intratracheal tube. Cardiac massage at the rate of 40 a minute should be given and 10 cc. of 1 per cent procaine injected intravenously or preferably intracardiac. One may also give $\frac{1}{2}$ cc. of 1/1000 epinephrine diluted to 10 cc. into the left ventricle. In one series of nine cases so treated there were three complete recoveries, one died of acute congestive heart failure after the second day and five remained unconscious because the interval between cardiac arrest and the onset of massage was too long and irreparable brain damage occurred. These unfortunate deaths all too often are totally unexpected in the patient with a normal heart and every operating room should be prepared to carry out these measures of resuscitation.

Footnote—Pronestyl, the amide of procaine is effective in the prevention and treatment of ventricular rhythms and is less toxic than quinidine.

HEALTHGRAM

The care, the study and the teaching of tuberculous disease today should be the responsibility of the broadly trained medical internist-investigator in close association with the highly proficient, experienced chest surgeon as part of the larger problem of the better understanding and control of all cardiopulmonary diseases involving the chest. Such an all-inclusive chest service should be an integral part of every large general hospital and medical teaching center, in the best interests of patients, physicians, undergraduate medical students and resident staff. This means medical center segregation in the future, rather than sanatorium isolation as in the past, with the tuberculous patient receiving equal acceptance and complete attention, including prompt recognition and specific treatment of his non-tuberculous complications which oftentimes threaten his existence more seriously than does the tuberculosis, itself. Ohio Pub. Health, May, 1950, Charles A. Doan, M.D.

THE DIFFERENTIAL DIAGNOSIS AND TREATMENT OF THE CORONARY DISEASES

PAUL T. RUSSELL, M.D.

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There are more than 35 pathologic conditions which may be mistaken for coronary artery disease. This presentation will be confined however, to the differential diagnosis of just the diseases of the coronary arteries and their treatment. By applying the basic fundamentals of physical diagnosis the differential diagnosis of coronary artery disease may, in a majority of cases, aid the physician in making an accurate early diagnosis of a patient's illness.

Without the aid of an electrocardiogram, the materials are available to any physician for evaluating the specific type of coronary artery disease problem with which he may be confronted. A careful detailed history is of the utmost importance in diagnosing chest pain of any type. In coronary artery disease the pain is usually associated with effort and exertion or occurs spontaneously and cannot be reproduced by deep inhalation or muscular effort. This one point can save the patient and the physician needless concern when considering the fact that pleurisy and various types of anterior and posterior thoracic wall muscular, spinal, and neural pain can give rise to symptoms resembling coronary artery disease. For practical purposes a safe criteria can be established in most cases of chest pain by the simple application of an accurate history.

The white and differential blood count, symptoms of shock, fever, sedimentation rate and blood pressure readings are almost diagnostic. Auscultation is of some assistance but the results may or may not reveal¹

precordial friction rub², rales at the bases of the lungs³, or cardiac arrhythmia because some of these findings occur hours after the onset of coronary artery occlusion. The electrocardiogram is of great importance in establishing a diagnosis of coronary artery disease. It reflects only the condition of the myocardium. Hence, it is just another link in the chain connecting together all available information. Most physicians have an electrocardiograph available and should not be satisfied with anything less than the standard limb leads, the aV leads and the V1-V6 leads.

Among the major coronary artery disease problems are: 1. Coronary artery occlusion; 2. Coronary insufficiency; and 3. Coronary athero and arteriosclerosis. There are several other pathologic coronary arterial diseases that do occur which should be mentioned. These are: Congenital anomalies, dissecting aneurysm, endarteritis obliterans, rheumatic infection, rupture, syphilis and trauma. This latter group is rare and are usually associated with other pathologic changes that give rise to coronary artery disease.

The classical textbook picture of acute coronary thrombosis is well known. Dr. Kenelm Winslow wrote, "The onset of an attack of coronary occlusion is so variable that a typical attack does not occur. Atypical episodes are rather typical of this disease. The symptoms vary in intensity from nearly nil to sudden death. Recovery is a matter of degree of the insult, the age of the patient, the existing state of the heart, the previous condition of the patient and his myocardium (and the grace of God), none of which may be apparent at the onset of a seizure of acute coronary thrombosis." Coronary artery occlusion at the onset is a medical emergency. Substernal pain which radiates to the left and/or right shoulder or neck, shock, ashen pallor, fall in blood

¹Read before the Medical Association of Georgia in annual session, Macon, April 20, 1950.

pressure, followed by temperature 99-102, increased sedimentation rate and leukocytosis indicate the presence of coronary thrombosis. Electrocardiographic findings shortly after the onset may be normal or abnormal. Occasionally there is one to several days lapse before the tracing shows S-T segment depression or elevation, and then a variety of T-wave changes such as— inversion, diphasic elements, cove-shaped T-waves, Q-wave increase and lowering of the R-wave. It is of considerable importance that the physician recognize the nature of the illness, start treatment and then rely on the electrocardiogram for confirmation of his diagnosis.

Angina pectoris is a *symptom* of a disease of the coronary vessels caused by circulatory insufficiency. The terms coronary insufficiency and angina pectoris are *not* synonymous. Apparently the primary factor behind angina pectoris is the same as the type of pain produced from any muscular structure which is deprived of an adequate blood supply.

In angina pectoris the heart sounds are not altered, the blood pressure is affected very little, physical signs are absent, laboratory findings show little or no variation from normal and in a majority of cases the symptoms subside before the physician arrives. However, occasionally a patient has had such attacks of pain during examination and EKG evidence obtained at that time show definite change manifested by relative myocardial ischemia. From 50 to 60 per cent of all patients suffering from recurring attacks of angina pectoris develop coronary thrombosis.

Usually the pain in coronary insufficiency is produced by exertion and may last for several minutes or several hours. There is a tendency for the pain to recur under mental stress and physical exertion. There is usually a history of recurring at-

tacks over a period of weeks, months or even years. When the patient is free of pain and presents himself for examination, the findings are usually vague and inconclusive. Here the case is important in differentiating from coronary artery disease.

The treatment of coronary occlusion is fairly well standardized as follows: 1. Morphine as needed to relieve pain; 2. Heparin as soon as diagnosis is established, given concurrently with dicumarol—Dicumarol = 300 mg. 1st 24 hours, 200 mg. 2nd 24 hours and adjust dosage according to prothrombin time for the next three weeks. Heparin does not require laboratory tests other than clotting time, but is expensive. It is given by vein or intramuscularly every 4 to 6 hours 50 mg. doses (undiluted—5 cc.). The dose at bedtime may be increased to 125 to 200 mg. In case of hemorrhage vitamin K 30 to 72 mg. intravenously and fresh blood transfusion.

3. Oxygen as needed. 4. Good nursing care and strict bed rest from four to six weeks depending on the progress of the patient. 5. Restricted activity for two to six months after dismissal from hospital. 6. Reassurance and avoiding any discussion that will fix in the patient's mind anxiety and worry over illness.

In *coronary insufficiency*, the nitrites and nitrates are still the most acceptable. Particular attention to diet, weight, rest, activity and emotional adjustment are the most important. The patient with frequent recurring anginal attacks is most often an emotional individual. It is to be remembered that over 50 per cent of the patients with recurring angina pectoris develop coronary thrombosis.

Arteriosclerosis and atherosclerosis of the coronary vessels are similar pathologic diseases with the exception that *atherosclerosis* frequently affects a *younger* age

group and is a special form of vascular disease *related to arteriosclerosis*.

Arteriosclerosis of the coronary vessels affects the sexes in equal ratio and does not *usually* occur until after age fifty. Various metabolic disturbances are predisposing factors in this illness. The more important are: diabetes mellitus, hypertension, hypothyroidism and essential xanthomatosis. In atherosclerosis, hypercholesterolemia may, in *addition* to the above conditions, may be responsible for resulting coronary vessel disease. The predisposing disease in arteriosclerosis and atherosclerosis applies to the vascular system as a whole and any involvement of the coronary arteries occurs in the process of a more *general* degenerative vascular change.

The diagnostic signs and symptoms of arteriosclerosis and atherosclerosis are not radically different from other pathologic conditions of the coronary vessels. The essential features are *angina pectoris*, *cardiac arrhythmia*, *heart failure* and *electrocardiographic changes*. The characteristic feature of the two diseases is the *gradual* onset of symptoms and the *progressive* course of the illness. Death may occur as a result of: 1. coronary occlusion; 2. cardiac failure; 3. cerebral or pulmonary embolism, or, 4. one of the predisposing factors of the original vascular disease.

The treatment of arteriosclerosis and atherosclerosis consists mainly of early recognition of the *basic metabolic disease* and its *proper management*. If diagnosis is made *late* in the course of illness, many of the vascular changes are *permanent*. When the coronary arteries are involved the disease may be considered to have reached a fairly advanced state and the treatment is that of the failing heart.

Here I should like to present a case illustrating *coronary insufficiency* which terminated in *massive coronary occlusion*:

The patient was a 50-year old white male whose

chief complaint was severe substernal pain upon slight exertion over a period of four months prior to admission to the hospital. The attacks were mild, short of duration and occurred at irregular intervals at the onset. Two weeks prior to hospitalization the anginal attacks were *more severe*, of *longer duration* and occurred at *frequent intervals*. During the course of the physical examination at the office, the patient had an anginal attack and an electrocardiogram was taken immediately. The physical examination was essentially negative, the pain subsided and the patient was sent home (because he refused hospitalization) with prescriptions for nitroglycerin and phenobarbital and advised to rest and restrict activity. Three days later the patient was admitted to the hospital due to severe, prolonged substernal pain and an electrocardiogram made the day of admission to the hospital showed myocardial damage. Twenty-four hours after admission, the patient *died*, and at *autopsy* there was found a massive clot in the descending branch of the left coronary artery and a myocardial infarct of 2 by 6 cm.

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PRACTICAL ASPECTS OF THE TREATMENT OF DICUMAROL INTOXICATION

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The advantages of being able to use anticoagulants with safety have broadened the scope of their usefulness to many medical and surgical indications. Both heparin and dicumarol, however, have distinct disadvantages. Heparin is expensive and its action is at best somewhat erratic. The continuous intravenous infusion of aqueous heparin needs frequent clotting times in order to control dosage because of the variable effect of a given dose, not only from patient to patient but in the same patient from time to time. The effect of

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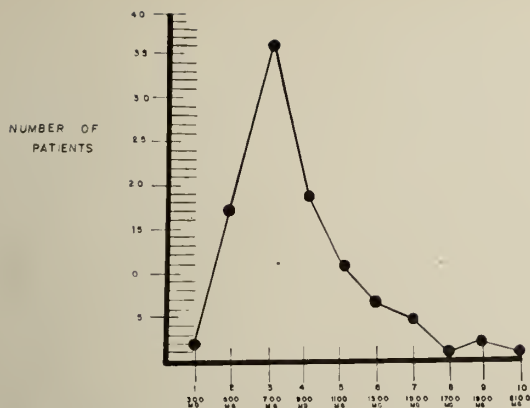


Fig. 1. Dicumarol required to prolong prothrombin time to beyond that of a 20 per cent normal plasma—initial course; 101 cases. Effect of intravenous administration of menadione sodium bisulfite U. S. P. on hypoprothrombinemia induced by ingestion of dicumarol.

intramuscular injection of such products as depo-heparin and heparin-pitkin-menstruum is by its very nature unpredictable in some degree. The administration of dicumarol, whereas it is inexpensive, has several distinct disadvantages as well: There is a significant and unpredictably delayed onset of therapeutic hypoprothrombinemia. Figure 1 demonstrates this in some detail. One hundred and one patients were given dicumarol orally in what has become a standard method of administration, i. e., an initial oral dose of 300 mg., followed by successive daily doses of 200 mg. until the prothrombin concentration is equal to or less than that of control plasma diluted with saline to 20 per cent. It can easily be seen that an important number of these; namely 26, required 5 days or more before their prothrombin times became lengthened to beyond that of 20 per cent control plasma. A similar lag period occurs before recovery from dicumarol effect ensues. Another disadvantage is the necessity of regulating dicumarol dosage by the result of frequent prothrombin determinations.

Despite these disadvantages, both of these anticoagulants deserve wider rather than more restricted utilization. Thus, more intimate knowledge concerning the

prevention or alleviation of intoxication becomes of great importance. There are three ways in which intoxication from excessive dicumarol effect can be alleviated. One is to allow the patient to recover unaided; the second is the transfusion of blood or plasma, thus reinforcing the prothrombin which his liver has been able to make with prothrombin derived from plasma or blood; the third consists of flooding the dicumarolized patient's liver with material having concentrated Vitamin K activity, so that the capacity of the liver to make prothrombin, under the adverse conditions produced by dicumarol, can be utilized to its utmost.

What is dicumarol intoxication? At first glance, the answer might seem obvious, but in fact it is not this easy. Dicumarol intoxication is usually accepted as meaning one of two things: (1) actual bleeding brought on by dicumarol (probably because of the production of hypoprothrombinemia); (2) excessive hypoprothrombinemia, even though bleeding does not occur. There is no doubt but that the occurrence of hemorrhage is a toxic reaction, but our experience has not borne out the idea that bleeding due to dicumarol is easily correlated from patient to patient with the degree of hypoprothrombinemia. In the past three years we have had the opportunity to study carefully and treat in various ways six individuals who were hemorrhaging because of dicumarol. Only one of these six had a prothrombin time prolonged to beyond that of 10 per cent control plasma. On the other hand, in the same period of time we have seen approximately a dozen patients with prothrombin times prolonged far beyond that of 10 per cent control plasma, who did not bleed at all.¹ This is not to say that excessive prolongation of the prothrombin time may not represent a source of danger

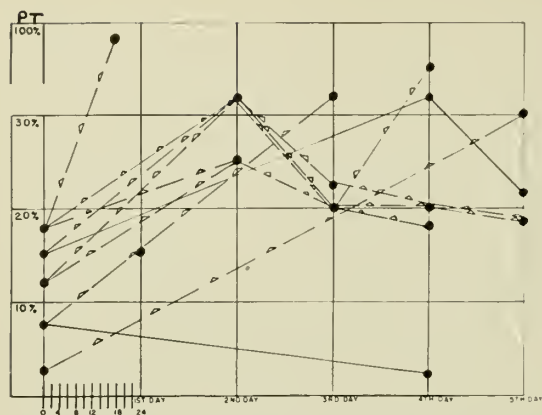


Fig. 2. Unbroken lines indicate values for a 64 mg. dose; the broken line with triangles indicates values for doses of 100 or 120 mg.

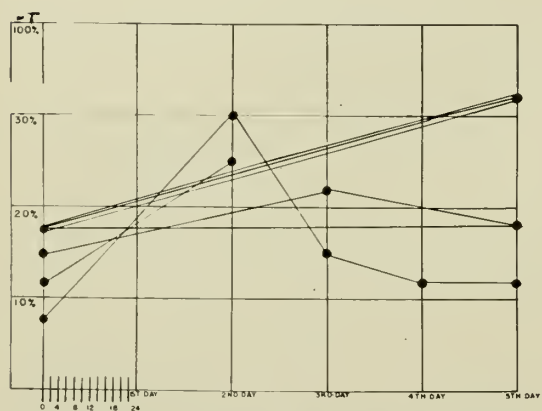


Fig. 3. The dose was 180 mg. Determinations of prothrombin time (PT) were made on plasma taken at intervals of 2, 4, 6, 8, 10, 12 and 18 hours after the menadione sodium bisulfite was administered, and then given daily thereafter. The prothrombin times are compared with the average of those for 3 normal subjects (undiluted plasmas, as well as plasmas diluted to 30, 20 and 10 per cent, as shown in the vertical column). Each line indicates the course of one patient. The only points plotted are those which show change in prothrombin concentration from one area of the figure to another. When the prothrombin time remained shorter than that of 30 per cent normal plasma, no more points were plotted. Otherwise, the course of the changes in prothrombin time was plotted for 5 days after treatment whenever possible.

to the patient, but it has served to emphasize to us that other factors than the concentration of prothrombin are important—the vascular status of the patient, the role of previous trauma to blood vessels, the state of nutrition, and other unknown factors must be significant in this regard. Accordingly, one who is using this drug must be aware of the fact that, whereas hemorrhage due to dicumarol is correlated with hypoprothrombinemia, many patients with excessive lengthening of the prothrombin time do not bleed, and that hemorrhage

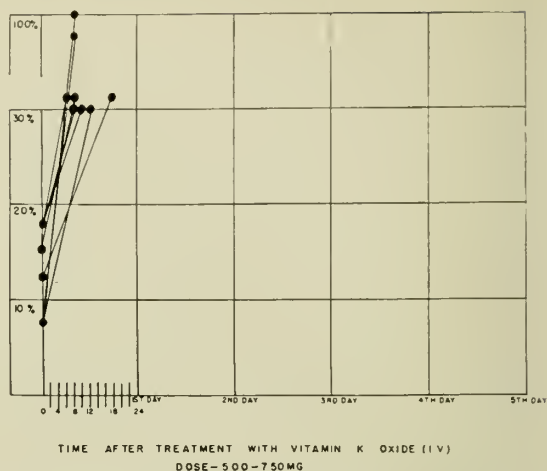


Fig. 4. Time after treatment with vitamin K oxide (I. V.).
DOSE—500—750 MG

may occur when the hypoprothrombinemia is only moderate.

The idea exists on the basis of insufficient data that if excessive hypoprothrombinemia or bleeding due to dicumarol occurs the injection of approximately 70 mg. of menadione bisulfite is sufficient to alleviate the trouble. That this is not so is indicated by our experience,² as demonstrated in Figures 2 and 3, which show that a single dose of this material, admittedly having good Vitamin K activity in these quantities, is insufficient to produce any remarkable change in the prothrombin time. We have had similar experience with the lack of success of these amounts of materials in the treatment of two patients who were bleeding from dicumarol intoxication, and the literature affords many other examples.³ We have had experience with the attempt at controlling dicumarol-induced hypoprothrombinemia in over 50 patients with hypoprothrombinemia, as well as 6 patients who were bleeding because of dicumarol effect, utilizing Vitamin K₁ oxide. Figure 4 demonstrates the remarkable effect of Vitamin K₁ oxide on dicumarol-induced hypoprothrombinemia in 13 patients when the dosage is over 500 mg. and the material is given intravenous-

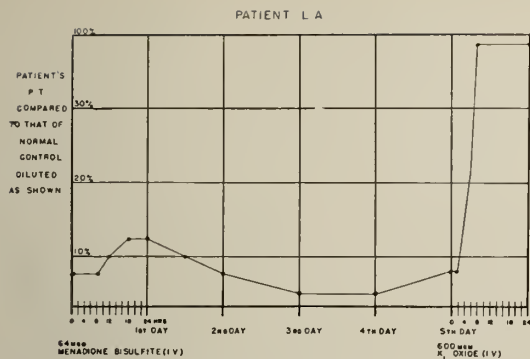


Fig. 5. Effect of single intravenous doses of menadione sodium bisulfite (64 mg.) and vitamin K₁ oxide (600 mg.) on the prothrombin time (PT) of a patient previously given dicumarol.

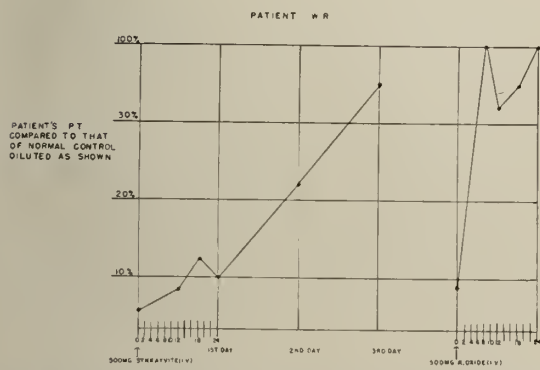


Fig. 6. Comparison of equal amounts of synkayvite and vitamin K₁ oxide (500 mg.) in the treatment of hypoprothrombinemia induced on two occasions by equivalent doses of dicumarol. PT indicates prothrombin time.

ly. This drug is not available for general use at the moment, but it is hoped that soon it will be available. The treatment of hemorrhage in the 6 patients we mentioned was about as spectacularly successful, alleviation of the bleeding (and coincident alleviation of hypoprothrombinemia) occurring within a space of 1 to 6 hours. I wish to present separately the charts of two patients who showed responses among the most dramatic to the administration of Vitamin K₁ oxide (Figures 5 and 6).

The administration of 500 cc. of fresh blood or stored blood is followed by an evanescent shortening of the prothrombin time, which soon, however, reverts to the prothrombin time which occurred before transfusion was begun. It appears from

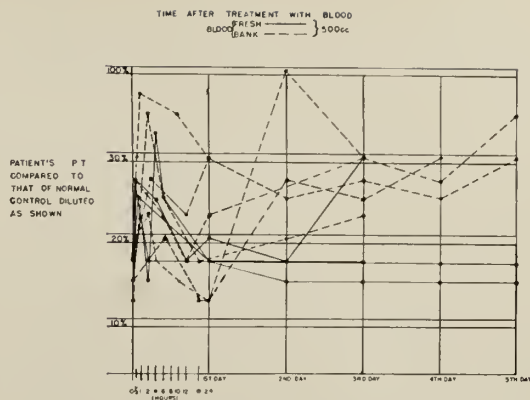


Fig. 7. Time after treatment with blood.

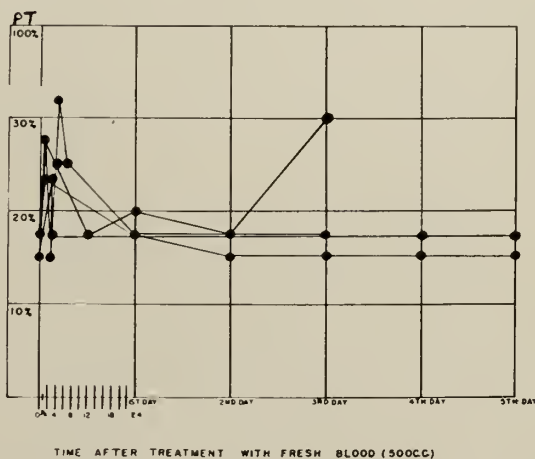


Fig. 8. Time after treatment with fresh blood (500 cc.).

our data that fresh blood and stored blood have about the same effect, (Figures 7 and 8), and that, whereas the physiologic effect of the replacement of blood may be important, the influence of these materials on hypoprothrombinemia induced by dicumarol is slight. Although we ourselves have no significant amount of information in regard to plasma, data from the reported literature support the idea that it is comparable in its effect to fresh or stored blood.

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METHODS AND USES OF CARDIO-PULMONARY FUNCTION TESTS

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Augusta

Introduction

Cardiopulmonary function tests are methods of studying physiologic disturbances secondary to diseases of the lungs, heart and great vessels. Cardiopulmonary function is a broad term and includes all of the physiologic processes active in respiratory and cardiocirculatory dynamics. Because of the functioning of these two systems as one unit to convey the respiratory gases between the outside air and the tissues, it is necessary to include both in such a discussion.

Cournand¹ has described a simple classification of pulmonary function and pulmonary insufficiency. More recently this has been somewhat modified by Baldwin² (Table 1). Pulmonary function is divided into two divisions: *Ventilation* is the mass movement of air from the outside into the lungs. In order for this to occur normally there must be well coordinated muscular movements, undiseased and elastic pleura, elastic and expansile lungs and a patent air way. *Respiration* is the exchange of oxygen and carbon dioxide across the pulmonary membrane. Normal respiration implies proper distribution of inspired air to alveoli and also proper diffusion of oxygen and carbon dioxide across the pulmonary membrane.

Pulmonary insufficiency, likewise, is divided into two parts: *Ventilatory insufficiency* depends upon the relation between the actual ventilation, which varies with the metabolic needs, and the maximal ven-

CLASSIFICATION OF PULMONARY INSUFFICIENCY

FORM	DISTURBANCE	SYMPTOMS
Ventilatory a Restrictive b Obstructive	Mechanical	Dyspnea
Alveolo-Respiratory a. Distributive b Diffusional	Mechanical and Physico-Chemical	Anoxia Hyper- ventilation

Table 1. Classification of Pulmonary Insufficiency (Medicine, 27:243, 1948).

tilatory capacity of the individual. Ventilatory insufficiency is a mechanical type of disturbance and its clinical manifestation is dyspnea. It may be *restrictive* as a result of disease of the chest wall, pulmonary or pleural fibrosis and of any disease which decreases the elasticity of the lungs. *Obstructive* ventilatory insufficiency results from obstruction of the airways. *Alveolo-respiratory insufficiency* is a mechanical and physicochemical type of disturbance and is manifested clinically by hyperventilation and cyanosis. Alveolorespiratory insufficiency is divided into *distributive* and *diffusional*. Approximately 80 per cent of the tidal air is distributed to the alveoli and is mixed with alveolar air sufficiently to produce an average alveolar oxygen tension of 103 mm. Hg. Lilienthal³ has demonstrated the existence of an oxygen pressure gradient across the pulmonary membrane and in normal individuals, in whom there exists a normal ventilation-perfusion ratio, this alveoloarterial oxygen tension gradient amounts to as much as 10 mm. Hg (Fig. 1). Under these circumstances there is good mixing of inspired air in the alveoli and good perfusion of the pulmonary capillaries. Perfusion of poorly ventilated alveoli produces an increase in the alveoloarterial gradient because blood perfusing such underventilated alveoli will be undersaturated with oxygen and this is effectively a shunt of venous blood. Such a disturbance in the ventilation-perfusion ratio occurs in emphysema.

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TRANSPORT OF GASES FROM INSPIRED
AIR TO ARTERIAL BLOOD

	INSPIRED	ALVEOLAR	ARTERIAL BLOOD
O ₂ mm. Hg.	150	100	90-100
CO ₂ mm. Hg.	0	40	40

Fig. 1. Transport of Gases from Inspired Air to Arterial Blood.

As a result of overdistention and loss of elasticity the alveoli may not properly fill and empty during the respiratory cycle so that inspired air is not properly mixed with alveolar air and the final alveolar oxygen tension may be too low to saturate the blood perfusing its capillaries. On the other hand, emphysematous alveoli may fill more readily and compress the adjacent relatively normal alveoli, producing hypoventilation of the latter. This, likewise, produces a decrease in the final p_{O_2} . Whether one or both modes are operative may depend upon the degree of bronchiolar obstruction and its relation to the filling and emptying of alveoli. Ventilation of poorly perfused alveoli results in less disturbance in arterial oxygen saturation unless there is extensive reduction in the pulmonary capillary bed. Impairment in diffusion of oxygen across the pulmonary membrane also increases the alveoloarterial gradient. Diffusional difficulties are encountered whenever there is any increase in the barrier to passage of gases across the pulmonary membrane. Thus pulmonary fibrosis, pulmonary congestion or edema, or any consolidation of the lung, inflammatory or neoplastic, may increase the A-A gradient enough to lower the arterial oxygen saturation.

Cardiocirculatory dynamics function jointly with ventilation and respiratory gas exchange in supplying tissue oxygen requirements and in elimination of carbon

dioxide. For this purpose there must be a large pulmonary vascular bed, producing sufficient surface for diffusion; also pulmonary and peripheral blood flows must be adequate in volume and speed. Cardiac disease, acquired or congenital, may produce a reduction in blood flow. Right to left shunts lower the arterial oxygen saturation and left to right shunts may cause cardiac decompensation because of the additional work thrown on the heart. Cardiac failure not only reduces the blood flow but increases the alveoloarterial oxygen tension gradient because of the associated pulmonary congestion and edema. On the other hand, pulmonary disease, such as fibrosis, with its associated vascular changes and impairment of diffusion of gases across the pulmonary membrane, produces hypertension in the lesser circulation and increases the work of the right heart.

Thus various combinations of ventilatory, respiratory and cardiocirculatory insufficiency are found. Ventilatory and respiratory insufficiency are rarely seen alone, but usually occur in combination with each other. Pulmonary insufficiency may be found without disturbance in cardiocirculatory dynamics, and cardiocirculatory insufficiency may exist in the absence of pulmonary insufficiency, but they frequently coexist.

Methods of Study

Lung volumes are measured by spirometric methods with any type of basal metabolism spirometer⁴ (Fig. 2). The *complemental* air is the maximal quantity of air that can be inspired from the resting expiratory level. *Reserve* air is the maximal quantity of air that can be expired from the resting expiratory level. The *vital capacity* is the quantity of air forced out of the lungs following a maximal inspiration and equals the sum of the complemental and the reserve air. The *residual* air is the amount of air remaining in the

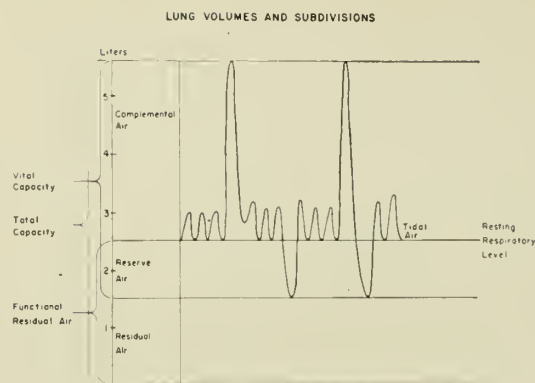


Fig. 2. Lung Volumes and Subdivisions (J. Clin. Invest. 11:1099, 1932).

lungs after a forced expiration and the *functional residual air* is the sum of the residual and reserve air. The residual air cannot be determined by ordinary spirometric methods and a simple open circuit method has been described by Darling⁵ and Cournand⁶. The subject breathes pure oxygen for seven minutes and during this time the expired air is collected in a Tissot gasometer. The residual air is based upon the quantity of nitrogen washed out of the lungs by the oxygen.

Lung volumes and their subdivisions may be altered by pulmonary disease. Total lung capacity is usually increased in emphysema⁷ and may be normal or decreased in pulmonary fibrosis⁸. Also in emphysema the resting expiratory level is shifted toward the inspiratory position. The ratio, $\frac{\text{residual air}}{\text{total capacity}}$ should not exceed 30 per cent; and an increase in this ratio indicates overdilatation of the lungs.

Maximum breathing capacity (M.B.C.) is the maximum volume of air that can be ventilated in unit time and is expressed in liters per minute. It is determined by having the subject perform maximal ventilatory efforts while the expired air is collected in a recording spirometer. Cournand^{1, 9} has established average normal values of 154 L/M for men and 100 L/M for women.

Breathing requirement is the actual ventilation of an individual in a given physical state and the *breathing reserve* is the difference between the maximum breathing capacity and the breathing requirement. Ventilatory insufficiency results from decrease in maximum breathing capacity or increase in breathing requirement or combination of both. Cournand¹ and Baldwin² have shown that at rest the breathing reserve should be approximately 91-95 per cent of the M.B.C. up to the fifth decade and may drop to 88 per cent in older subjects. Also they have shown that an individual is dyspneic at rest when the breathing reserve is reduced 60-70 per cent of the maximum breathing capacity. Thus, the ratio, $\frac{\text{B.R.}}{\text{M.B.C.}}$, may be used to gauge the extent of ventilatory insufficiency.

Ventilatory Reserve or ratio, $\frac{\text{Maximum breathing capacity}}{\text{Resting minute ventilation}}$, has been used by Ornstein¹⁰ as a measure of ventilatory insufficiency. Normal values are 20 for males and 13 for females.

The *Index of Intrapulmonary Mixing of Gases*⁶ is useful to detect alveolo-respiratory insufficiency. The subject breathes pure oxygen for seven minutes, at the end of which the alveolar nitrogen should be below 2.5 per cent. Improper distribution and poor mixing of inspired air, as occur in emphysema, cause some of the nitrogen to be retained within the alveoli and thus an index above 2.5 per cent.

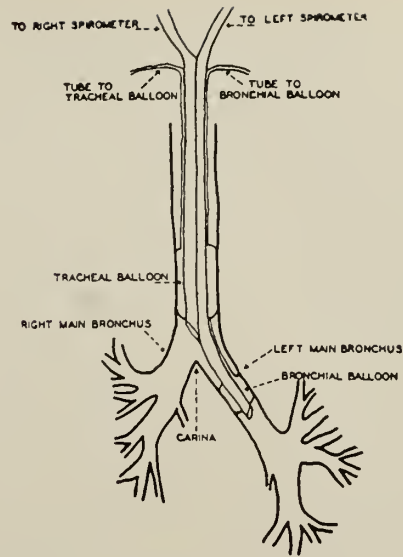
Ventilation and Gas Exchange at Rest, during exercise and recovery. Under basal conditions the subject breathes atmospheric air while expired air is collected in a recording spirometer for five minutes. During the fifth minute an arterial sample of blood is taken from the brachial artery. Then the subject performs a standard one

minute exercise, during which the expired air is collected in a Douglas bag. He then lies down and during five minutes of recovery expired air is collected in a recording spirometer. A sample of arterial blood is taken during the first minute of recovery. Analysis of expired air for oxygen and carbon dioxide is carried out in a Haldane apparatus and blood gas analysis is done in a Van-Slyke apparatus¹¹. Arterial oxygen and carbon dioxide tensions are determined by the Riley technic¹².

Resting ventilation is the breathing requirement of an individual at rest and is useful in determining the breathing reserve. Oxygen consumption at rest has been shown to be about 130 cc/M/M² body surface and during the one minute exercise should increase to greater than 400 cc/M/M² body surface. A reduction in the oxygen consumption may be related to (1) ventilatory insufficiency when the maximum breathing capacity has been markedly decreased, or (2) to an increased alveoloarterial gradient as a result of disturbance in the ventilation-perfusion ratio or diffusional difficulties, or (3) to decrease in the cardiac output. Determination of the arterial oxygen tension is useful because as a result of the shape of the oxyhemoglobin dissociation curve a considerable decrease in oxygen tension may exist in the presence of little change in saturation.

Normally arterial blood is 96 per cent saturated and saturation should not drop below 95 per cent during exercise. In the absence of a true venoarterial shunt a lowering of the arterial oxygen saturation indicates that there are large areas in the lungs in which alveoli are well perfused with blood and poorly ventilated or that diffusion of oxygen across the pulmonary membrane is impaired or both².

*Bronchspirometry*¹³ is the spirometrical study of the functions of each lung. The



SCHEMATIC DRAWING ILLUSTRATING THE FLEXIBLE DOUBLE AIRWAY RUBBER TUBE USED FOR BRONCHOSPIROMETRY

Fig. 3. Schematic Drawing Illustrating the Flexible Double Airway Rubber Tube Used for Bronchspirometry (Medicine 27:243, 1948).

tracheobronchial tree is anesthetized, as for bronchoscopy, with 0.5 per cent pontocaine topically. A Zavod catheter¹⁴ (Fig. 3) is introduced through the larynx into the trachea and under fluoroscopic guidance is directed into the left main bronchus. Each lumen of the catheter is connected to a separate spirometer and ventilation, oxygen consumption, and vital capacity are recorded. By this method the relative functions of each lung can be determined. It has been shown that the functions of the right and left lungs are 55 per cent and 45 per cent respectively. Frequently a lung, which roentgenologically is severely diseased, will contribute its normal share of the total oxygen consumption; and vice versa, a lung which shows little evidence of disease may take up only a very small part of the total oxygen consumption¹⁵. The oxygen consumption of a single lung may be considered an index of the relative circulation to that lung unless there is a decreased arterial saturation as a result of improper ventilation-perfusion ratio or impaired diffusion across the pulmonary membrane².

Tests of cardiocirculatory insufficiency should, of course, always include clinical studies such as electrocardiograms, roentgenograms, fluoroscopy, circulation time, venous pressure, etc. *Cardiac catheterization*^{16 17} has added much to the knowledge of cardiopulmonary dynamics and is now a commonly used procedure. A modified ureteral catheter is inserted into an antecubital vein or in infants and children into the internal saphenous vein and advanced under fluoroscopic guidance into the right heart. Pressures are recorded by means of Hamilton manometer¹⁸ and samples of blood removed from each chamber are analyzed for oxygen and carbon dioxide in a Van Slyke apparatus. An arterial needle is placed in the brachial artery. Pulmonary and peripheral blood flows are obtained according to the Fick principle by simultaneously withdrawing samples of arterial and mixed venous blood and recording oxygen consumption with a recording spirometer. Normal pressures have been established to be $\frac{25}{8}$ mm. Hg

for the pulmonary artery, $\frac{25}{2}$ mm. Hg for the right ventricle and $+ 2.2$ mm. Hg for the right auricle^{16 17 19}.

Cardiac catheterization is a valuable adjunct to the methods of studying various cardiopulmonary disorders. Many congenital heart lesions are amenable to surgery, and catheterization studies may provide a better understanding of the disturbed dynamics and thus aid in the selection of cases for surgery. Occasionally a patient is saved an exploratory operation or catheter studies may indicate a particular surgical procedure. These studies also often provide helpful information in acquired heart disease, such as cor pulmonale and mitral stenosis. For example, elevation of the right auricular pressure in a patient

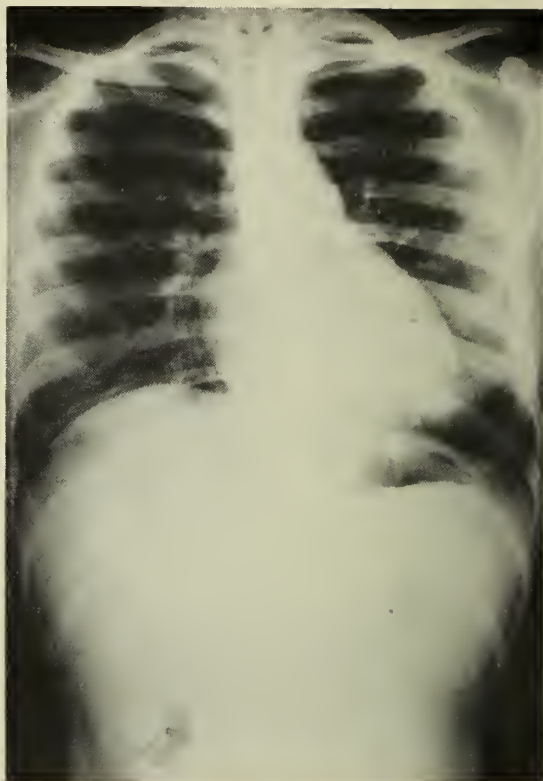


Fig. 4. Case 1. Prominent Pulmonary Artery.

with mitral stenosis contraindicates an operative procedure such as a Sweet-Bland shunt.

These methods of studying cardiopulmonary function frequently reveal evidence of physiologic disturbances which are not apparent clinically and may be of great aid in predicting prognosis. They provide a measurement of pulmonary reserve which may be useful in the evaluation of patients prior to permanent forms of collapse therapy or surgical removal of lung tissue. In addition, the effectiveness of various types of surgical treatment in pulmonary diseases can be determined.

Illustrative Cases

The following cases illustrate the application of some of the above described methods:

Case 1. Patient P. W., a 15 year old white female, was found to have a cardiac murmur during a routine school examination. She was asymptomatic, but her family physician thought that her cardiac lesion was probably a patent ductus arteriosus and referred her to the University Hospital for study. Her history revealed that she had had the usual childhood diseases,

CARDIAC CATHETERIZATION PATIENT P. W.

LOCATION CATHETER	MM HG	O ₂ CONTENT VOL. %	SATURATION %
P. A.	$\frac{20-25}{10}$	11.5	78.5
R. V.	$\frac{45}{0}$	11.1	76.
R. A.	+5-5	11.5	78.5
S. Vena Cava		11.25	77.
I. V. C.		11.71	80
B. A.	$\frac{100}{45}$	13.89	95

Table 2. Cardiac Catheterization. Patient P. W.

without complications, or sequelae. At age three she had pneumonia, complicated by left empyema, which was treated successfully by intercostal drainage. There was no history of rheumatic fever, dyspnea, cyanosis, or any other symptoms referable to the heart or lungs. Physical examination revealed an apparently healthy 15 year old white female. There were no clubbing of fingers and no evidence of cyanosis at rest or during exercise. Blood pressure and pulse rate were normal. The heart was of normal size to percussion. In the second intercostal space just to the left of the sternum a loud blowing systolic murmur could be heard. On admission a slight diastolic murmur was audible in this same location, but on later examinations there was some question about its existence. The systolic murmur was transmitted over the entire precordium. X-rays (Fig. 4) and fluoroscopy revealed prominence of the pulmonary artery and normal pulsation of the pulmonary radicles. There was no cardiac enlargement. A presumptive diagnosis of probable patent ductus arteriosus was made, but in the absence of a diastolic component it was felt that other possibilities were pulmonary stenosis, interatrial or high interventricular septal defects. Cardiac catheterization was carried out and the results are recorded in Table 2. The fact that samples from all chambers had no more variation in oxygen content than is normally expected ruled out any type of shunt. Normally the pressure drop across the pulmonary valve during systole is zero. In this case there was a 25 mm. Hg fall in pressure, due to a slight decrease in pulmonary artery systolic pressure and an increase in right ventricular systolic pressure, the diastolic pressure in the right ventricle remaining normal. These findings indicated a pulmonary stenosis with post-stenotic dilation of the pulmonary artery. It was felt this girl was well compensated to this congenital anomaly and that surgical intervention was contraindicated.

Case 2. Patient C.S.S. was a 41 year old white male whose bilateral pulmonary tuberculosis was discovered in 1942. He received a right pneumothorax from February 1942 to May 1945. Pleural fluid developed and the pneumothorax space obliterated, leaving very pronounced fibrosis of the pleura and some fixation of the diaphragm. Left pneumothorax was established in October 1944 and continued until August 1947; pneumoperitoneum was started in August 1947 and discontinued in June 1949. Left phrenicopleurax was done in March 1948, but diaphragmatic movement had returned by June 1949. His sputum remained persistently positive for acid fast bacilli and it was felt that the lesion in the left apex was responsible for the positive sputum (Fig. 5). There was marked retraction of the right chest with very little expansion, but very good expansion on the left. He was dyspneic on slight exertion and it was thought that the left lung was probably performing most of

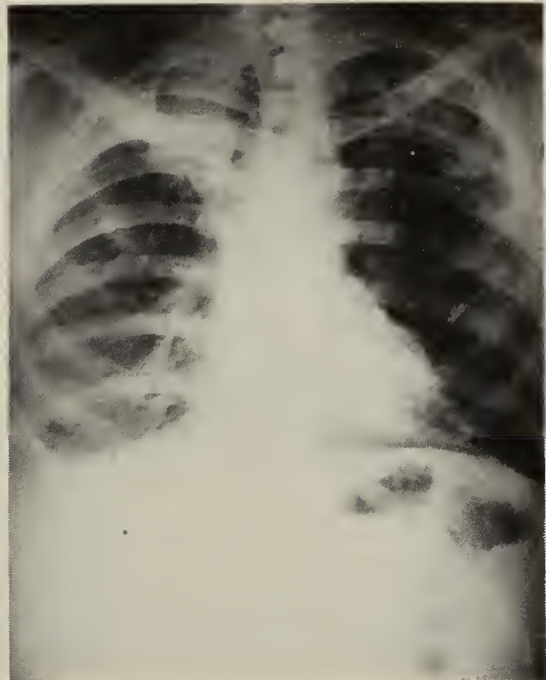


Fig. 5. Case 2. Pleural Fibrosis and Retraction of Right Thorax. Cavitation Left Apex.

LUNG FUNCTION STUDIES PATIENT C.S.S.

MEASUREMENT	PREDICTED	OBSERVED
Lung Volumes		
Vital Capacity	3910	1650
Residual Air	1200	1302
Total Capacity	5100	2952
Residual	23.5%	44%
Total Capacity		
Maximum Breathing Capacity	118 L/M	52 L/M
Intrapulmonary Mixing	2.5% N ₂	1.99% N ₂
Saturation Arterial Blood		
Rest	96%	95%
Step Exercise	95%	80%

Table 3. Lung Function Studies. Patient C.S.S.

BRONCHOSPIROMETRY PATIENT C.S.S.

	RIGHT	LEFT	TOTAL	% TOTAL R	% TOTAL L	SPIROMETRY
Ventilation (cc/m)	672	4479	5151	13	87	5200
O ₂ Intake (cc/m)	69	161	230	30	70	223
Rate O ₂ Removal (cc/L)	113	42				49
Vital Capacity (cc)	342	1045	1387	25	75	1665
Reserve Air (cc)	124	300	424	29	71	387
Tidal Air (cc)	84	558	642	13	37	698

Table 4. Bronchspirometry. Patient C.S.S.

his pulmonary function. It was felt that a left thoracoplasty would probably convert his sputum, but since his left lung was better functionally than the right, it was doubtful that he could tolerate further reduction in his pulmonary reserve. The results of pulmonary function studies are recorded in Tables 3 and 4. The total capacity was reduced probably because of extensive fibrosis and residual air was increased as a result of overdistention of alveoli uninvolved by fibrosis. In spite of the increased residual air he was

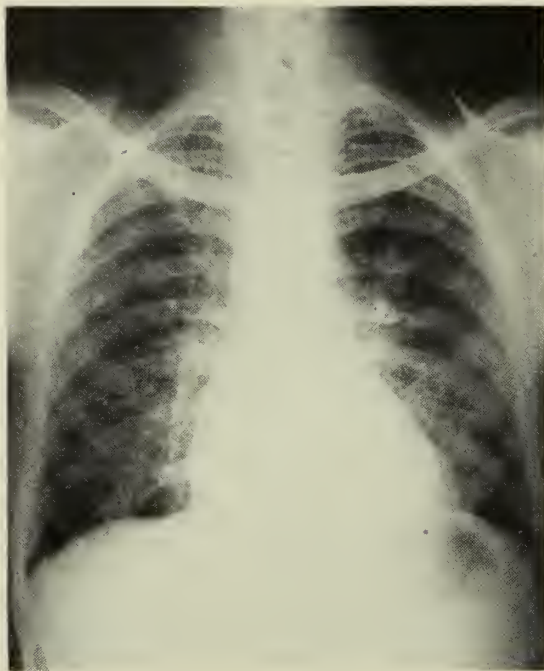


Fig. 6. Case 3. Diffuse Pulmonary Fibrosis.

able to maintain normal intrapulmonary mixing of inspired air by hyperventilation. Because of marked reduction in maximum breathing capacity and hyperventilation there was considerable reduction in his breathing reserve. He was unable to tolerate a standard step exercise and on slight exercise his arterial oxygen saturation fell to 80 per cent. Bronchspirometrical studies confirmed the clinical impression that the left lung was performing most of the total function. It was felt that this patient would not tolerate a left thoracoplasty and if he did survive such a procedure, he would be left a respiratory cripple.

Case 3. Patient R.S., a 31 year old colored male, was admitted to the University Hospital on September 30, 1949, complaining of generalized swelling and shortness of breath. His shortness of breath was first noticed approximately seven years prior to this admission. Two and one half years previously he had developed a hacking cough, sometimes productive of mucoid sputum. By this time he was dyspneic on slight exertion. He had been hospitalized several times previously, the last being in March, 1949. At the present admission he was severely dyspneic. Moist rales were heard throughout both lung fields. The heart was enlarged to the left and systolic and diastolic murmurs were heard loudest at the mitral area, but could not be satisfactorily evaluated because of tachycardia of 140. The abdomen was distended with fluid, the liver was enlarged downward, and there was pitting edema of the ankles. X-rays of his chest revealed evidence of extensive pulmonary fibrosis (Fig. 6). The history was noncontributory as regards causes of the fibrosis. His heart failure subsided readily although slowly to a cardiac regime and after he had become compensated cardiac catheterization was performed. The results of catheterization in March and October 1949 are recorded in Tables 5 and 6. During the interval of seven months between catheterizations his pulmonary hypertension had become more pronounced. The normal pulmonary capillary pressure indicated that the pulmonary hypertension was due to pulmonary arteriolar changes rather than to back pressure from the left auricle. The fact that the arterial blood became almost completely saturated while the patient was breathing 100 per cent oxygen supported the

CARDIAC CATHETERIZATION PATIENT R.S. 3-9-49

POSITION CATHETER	MM HG	O ₂ CONTENT VOL. %	SATURATION %
Pul Artery	$\frac{45}{25}$		
Right Ventricle	$\frac{35}{3}$	15.87	57
Brachial Artery		20.83	75

Table 5. Cardiac Catheterization. Patient R.S. (3/26/49).

CARDIAC CATHETERIZATION PATIENT R.S. 10-26-49

POSITION CATHETER	MM HG	O ₂ CONTENT VOL. %	SATURATION %
Pulmonary Capillary	0-10		
P. A., Right	$\frac{75}{35}$	8.00	46.5
Right Ventricle	$\frac{75}{0}$	7.11	41.0
B. A. - Air		12.58	73.0
B. A. - Oxygen		17.20	100.

Table 6. Cardiac Catheterization. Patient R.S. (10/26/49).

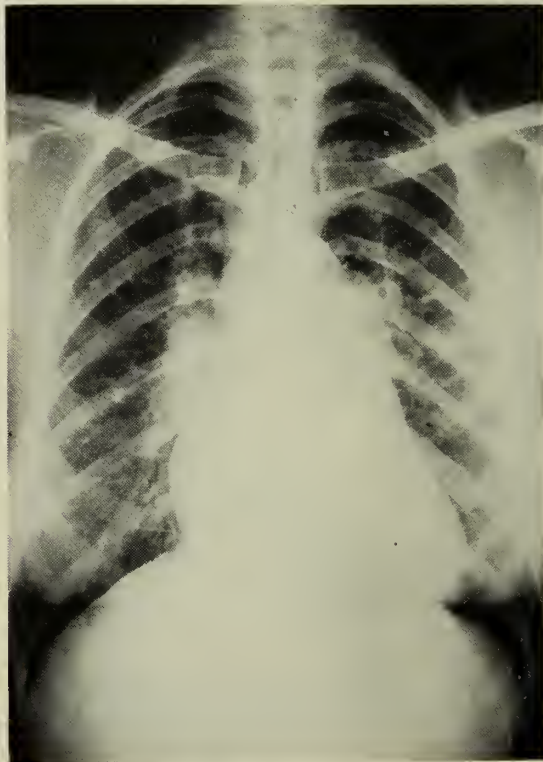


Fig. 7. Case 4. Mitral Stenosis. Cardiac Enlargement. Prominent Pulmonary Artery. Pulmonary Congestion.

impression that the low arterial saturation (73 per cent) on ambient air was due to alveolo-respiratory insufficiency as a result of disturbance in diffusion of oxygen across the pulmonary membrane.

Case 4. Patient G.E.S., a 32 year old white female, was admitted to the hospital with a diagnosis of rheumatic heart disease with mitral stenosis. For three years prior to admission she had had frequent attacks of pulmonary edema with hemoptysis, precipitated by the slightest effort. X-ray (Fig. 7) and fluoroscopy revealed pronounced pulmonary congestion,

CARDIAC CATHETERIZATION PATIENT E.G.S

POSITION CATHETER	MM. HG.	O ₂ CONTENT VOL. %	SATURATION %
Pul Cop	15-30		
P A	100-75 35-35		
R. V.	100-75 0-0	9.95	53.
R A	-5-0		
B A		15.02	80.4

Table 7. Cardiac Catheterization. Patient E.G.S.

prominence of the pulmonary artery and enlargement of the right ventricle. The results of catheterization are recorded in Table 7. Elevation of the pulmonary capillary pressure confirmed the clinical impression that the pulmonary hypertension was due to back pressure from the left auricle. The fact that the pulmonary capillary pressure nearly equaled the diastolic pressure in the pulmonary artery indicated that the resistance in the pulmonary artery was low. Thus catheter studies ruled out any secondary changes in the pulmonary vascular bed and revealed evidence of competency of the right ventricle. In view of these facts and the marked limitations of the patient, it was felt that she was a candidate for the Sweet-Bland shunt.

Summary

A classification of cardiopulmonary insufficiency has been reviewed and methods of study, which have been adopted by the cardiopulmonary laboratory at The Medical College of Georgia, have been discussed. Four cases have been presented to illustrate some of these methods. It should be emphasized that these methods, when properly used, are valuable adjuncts to clinical methods of evaluating cardiopulmonary function.

The author is particularly indebted to Dr. W. F. Hamilton, Sr. for advice and guidance, to Dr. W. F. Hamilton, Jr. for assistance with cardiac catheterization, and to Mrs. Christine McCoy for technical assistance.

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DISCUSSION

DR. J. A. REDFEARN (Albany): *Cardiac Arrhythmias*. As a rule you are justified in assuring the patient that the disturbance is not dangerous and the heart is not diseased. Skip beats are the most frequent disturbance of rhythm and paroxysmal tachycardia ranks second. Neither is classed as heart disease and the heart needs no treatment. The causes should be found and treated. Sometimes they are caused by some diseases but usually tobacco, coffee, tea, alcohol, indigestion and focal infection are the most likely contributions.

Auricular fibrillation, when chronic, is usually associated with heart disease and requires treatment with digitalis and perhaps with quinidine unless there is chronic congestive failure, or a greatly enlarged heart.

Paroxysmal auricular fibrillation may be due to rheumatic heart disease or thyroid disease. Occasionally it is a benign disturbance of rhythm most often produced by indigestion. Slow auricular fibrillation without other symptoms of heart disease needs no medical treatment. The doctor's presence is sufficient treatment for 90 per cent of these patients regardless of treatment prescribed.

Remember that you generally have plenty of time for treatment of the arrhythmias except ventricular fibrillation which is rare. Life here is often ebbing away.

Treatment of coronary diseases. In treating angina pectoris it is important to teach the patient that nitroglycerin should also be used to prevent attacks as well as to relieve pain. Aminophyllin 4 grs. given intravenously will often relieve the pain of coronary occlusion but so will morphine and dilaudid.

Rest and reassurance, liquid diet during the first few days and oxygen when there is dyspnea or cyanosis.

Start anticoagulants early and continue for a month. Stop tobacco among the addicts. When healing has

taken place, permit a return to any reasonable occupation with the assurance that "all is well." "Nature abhors inactivity," so encourage the coronary patient to return to sensible mental and physical activities as soon as you deem it safe.

STREPTOMYCIN FAILURES IN TUBERCULOSIS

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Rome

Streptomycin has now been in use for four years since Hinshaw¹ and his associates first applied it in the treatment of tuberculosis. While this is the most effective drug against tuberculosis, it must be admitted that streptomycin alone does not cure tuberculosis and those who are in the best position to judge its effectiveness are of the opinion that improper use is not only ineffective but is actually dangerous since, under certain conditions, the patient's ultimate chance for recovery may be lessened. For this reason the staff at Battey Hospital feel that a presentation of streptomycin failures as we have observed them will be helpful to the general practitioner in making a selection of cases for treatment.

Tuberculosis meningitis is for practical purposes always fatal without chemotherapy. Failure with streptomycin is almost certain if diagnosis is delayed, if overdosage by intrathecal administration is practiced and if the disease has developed after a previous course of streptomycin has been given and resistance has developed. One other factor makes the prognosis very grave, namely miliary tuberculosis. Overwhelming toxicity, either from the meningeal process or from tuberculosis involving other organs, is another sign that streptomycin will probably be a failure.

Since 1946 we have treated 22 patients at Battey Hospital with tuberculous menin-

gitis and 7 have recovered with all but one having gone longer than 2 years. This is an overall better result than the 20 per cent survival rate reported by the Veterans Administration and yet the results are not as good as reported by Dr. Lincoln² at Bellevue with children. It is interesting to note, however, that 11 of these patients were already at Battey when their meningitis developed and of these 11 there were 6 recoveries and there was only one patient who recovered in the 11 who were sent to Battey with meningitis. It is also interesting that of the 6 recoveries from these early diagnosed cases that there are no significant neurological stigmata except for partial deafness in three. The other recovery has a complete cord block. This correlated very well with the fact that of the ten patients who had presented symptoms for less than 1 week only 4 or 40 per cent died, whereas only one of 8 patients recovered who had had symptoms for 1 to 3 weeks, and none of the 4 having symptoms longer than 3 weeks. This makes it imperative that meningitis be suspected early, that treatment be started early and continued until diagnosis can be ruled out. If there is headache, nuchal rigidity or resistance, and with increased cells, low sugar and low chlorides in the spinal fluid we start treatment and wait for bacteriologic confirmation.

We give 100 mg. streptomycin intrathecally every 2 days for 1 to 2 weeks and then drop to 50 mg. twice weekly for 2 to 3 months and then once weekly until 4 to 5 months have elapsed. This should be well diluted with saline and spinal fluid (20 cc.). If the spinal fluid becomes yellow and the protein content rises or if the spinal fluid shows red cells, other than those due to the tap, the dosage and frequency should be dropped until signs of irritation have disappeared. Intramuscular streptomycin

¹Read before the Medical Association of Georgia in annual session, Macon, April 20, 1950.

in dosages of 1 to 2 Gm. per day should be given along with paraaminosalicylic acid in doses of 10 to 15 Gm. per day. Streptokinase should be used if cell count is high or if there is evidence of block.

Our experience with miliary tuberculosis has been wholly unexpected in that most cases have recovered except for those who developed meningitis. In that respect our experience has been similar but slightly better than that of the Veterans Administration³ who report less than 10 per cent survival. We have treated less than 12 cases of miliary tuberculosis, however, and this is not a significant number from which to draw conclusions.

We have treated and observed from two to three years afterward, 15 patients with glandular tuberculosis. Failure is likely to occur if the glands have shown much destruction by caseation, unless they are drained or removed, and the patients which we had with dissecting lesions involving the chest wall, mediastinum and axillary areas have all died. We advocate the surgical removal of glands under the protection afforded by streptomycin with follow-up period of bed rest for 6 months to 1 year. This period of bed rest is an absolute essential since glandular tuberculosis is always secondary to other foci in the body and the patient may relapse with pulmonary, peritoneal or some other form of tuberculosis.

The treatment of bone tuberculosis with streptomycin is likely to be a failure unless the lesion is very early without local abscess formation and without bony destruction. If the patient has a pulmonary or other lesion which contraindicates surgery, streptomycin should be withheld until it can be used as an adjunct to surgery and not as a definitive treatment alone.

The treatment of tuberculous peritonitis is likely to be a failure if there is extensive enteritis with partial obstruction and with

leakage of caseous material. If peritoneal fluid be present it should be drained and if pneumoperitoneum is being given it should be abandoned.

In renal tuberculosis showing caseous lesions streptomycin treatment without surgery is almost certain to be a failure. If the lesion or lesions, can be successfully resected under streptomycin coverage there is an excellent chance for recovery. Of the 6 patients that we have observed for 2 years or longer as being apparently well, 4 have had surgery with their streptomycin.

In pulmonary tuberculosis any treatment regimen will be a failure which fails to take into consideration the pathologic changes and the natural course of healing with all of its little understood variations in different individuals. There is apparently one main cause for failure of streptomycin which is the emergence of organisms who are resistant to its action in much higher concentrations than can ever be obtained in the body. The other reason is the fact tuberculous lesions in the body develop in such a manner that the blood supply may actually be so poor that the drug never reaches all of the organisms in an effective concentration.

Whatever the reason for failure, we know that fibrocaseous lesions fail to show response to streptomycin almost in direct ratio to the amount of caseous disease present. Since these usually represent the bulk of the chronic pulmonary tuberculosis that is ordinarily seen by the physician it is evident that routine use of streptomycin is without benefit. This type of patient, as a rule needs to be treated with collapse therapy and he frequently has bronchial lesions which contribute to partial bronchial blockage and which will be benefited by streptomycin particularly if it is part of a well planned treatment approach. Collapse is still an absolute must in the

treatment of most cases of chronic pulmonary tuberculosis and chemotherapy should not be attempted until the patient has had complete laboratory and clinical study and a treatment regimen outlined to carry him to an eventual cure even though it will take 5 years or longer.

Minimal lesions usually will heal without streptomycin and in the light of our present knowledge its use is contraindicated. It is therefore a failure if it will not improve the chance of cure and especially since the individual may have a later spread to the meninges and will be resistant.

Streptomycin is certain to be a failure if the physician or patient thinks that it will shorten the period of bed rest which is necessary after the lesions have become stabilized and are beginning to heal. This period of rest, not only while the lesion is clearing, but for a 6 to 12 months period after clearing has stopped, can not now be avoided by any method or combination of methods. It is true that streptomycin will clear the exudative component in a very high proportion of all cases but unless the patient fails to consolidate his gains by observing strict bed rest his treatment will be an ultimate failure because he will spread and will then be resistant to the drug.

In summary let us suggest that streptomycin not be given to any patient, except those with miliary tuberculosis and meningitis, until the patient has had a review by the person who is to be responsible for his management throughout his course of treatment. The use of bed rest, collapse and other methods of treatment can all be enhanced by the judicious use of streptomycin in certain selected cases, but its use too early may leave the patient resistant and he may come to the point where its action will be the only thing that will save his life. Nothing in these remarks are to be construed as condemning the use of

streptomycin as a palliative when all hopes of cure are past. There is no drug, including morphine, which will give relief in terminal tuberculosis that is as effective as is streptomycin. This use should be carefully weighed, however, especially in the home, where there is the possibility that the individual may pass along streptomycin resistant organisms to other persons.

BENTYL HYDROCHLORIDE: A NEW ANTISPASMODIC AGENT

Clinical Evaluation in Gastrointestinal Diseases

CHARLES W. HOCK, M.D.

Augusta

A new compound, bentyl hydrochloride (betadiethylaminoethyl 1-cyclohexylcyclohexanecarboxylate hydrochloride) has been demonstrated in animals to possess both a parasympathetic (atropine-like) depressant and musculotropic (papaverine-like) action¹ on the smooth musculature of the gastrointestinal tract. Minimum effect upon salivary secretion and function of the ciliary muscle appears to be a characteristic property of the drug. Because of the large potential margin of safety it has been given to human subjects as outlined below, and highly encouraging preliminary observations have been made.

Bentyl hydrochloride has been given to 67 patients (21 males and 46 females, varying in age from 16 to 80 years) suffering from the following symptoms associated with spasm of the gastrointestinal tract: abdominal pain, 38 instances; spastic constipation, 23; "gas" (distention, bloating, flatulence, eructation), 16; diarrhea, 13; nausea, 13, with vomiting, 6; abdominal cramps, 10; regurgitation, 4; pain in

¹From the Medical College of Georgia.

Bentyl Hydrochloride is a registered trademark of The Wm. S. Merrell Company, Cincinnati, Ohio, and the material was furnished by them.

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chest, 3; anorexia, 2; and dietary intolerance, 1 instance.

These symptoms were associated with the following conditions: functional bowel distress, 58 cases; duodenal ulcer, 4; gall-bladder disease, 3; cancer of digestive tract, 2; diverticulosis and diverticulitis, 2; gastritis, 2; proctitis, hepatitis, gastric ulcer, amebiasis, 1 each.

The drug has been administered orally to all patients before or after meals and occasionally at the hour of sleep. In 44 cases the dose was 10 mg. given three times daily, and in 15 a dose of 20 mg. three to four times daily was required. The maximum dose was 130 mg. given three times daily to two patients. One of the patients described a "jerking" sensation in his head on doses of 390 mg. daily; the other patient tolerated 13 times the usual dosage without any side effects.

Fifteen of the patients required concurrent sedation to obtain the maximum benefits of therapy and they were given tablets of the compound preparation containing 10 mg. of bencyl with 15 mg. phenobarbital.

In the treatment of patients with functional disorders of the gastrointestinal tract, it is of utmost importance that the patient be given a very careful analysis because of the difficulty of properly evaluating and differentiating the symptoms of organic disease from those of functional origin. Moreover, the use of antispasmodic therapy must be regarded essentially as an adjunct to fundamental measures consisting most importantly of dietary regulation, correction of organic lesions, sedation and psychotherapy. In combination with such therapy, virtually complete symptomatic relief was obtained with bencyl hydrochloride in 23 cases, while partial but usually highly gratifying relief resulted from therapy in 39 additional cases. Of the total

series of 67 patients, little or no relief was obtained in only 4 cases. Two of these patients suffered from functional bowel distress, 1 from gastric ulcer, and one from cancer of the sigmoid. It is interesting, therefore, to note that gratifying to complete relief from symptoms was obtained in a total of 56 of the 58 cases of functional bowel distress, the largest single type of patient in this study.

Thirty-seven patients were treated for three months or longer, while the entire duration of therapy varied from two weeks to thirteen months. During this period no abnormalities were detected in the red and white blood counts, hemoglobin determinations or urinalyses in the 21 patients who were treated for long enough periods to justify such studies.

Side effects were unusually mild and transient, being limited to two patients who reported some degree of headache and vertigo thought to be associated with administration of bencyl, 1 whose spastic constipation appeared to be worse, and 1 who described a sensation of "light-headedness". The patient who described a jerking sensation in the head on 13 times the usual dosage (130 mg. three times daily) has already been mentioned.

Most of the patients who were selected for treatment with bencyl belonged to the group that had not received satisfactory benefit from older antispasmodic drugs. Specifically, a preliminary trial period with belladonna and phenobarbital was found to be less effective than bencyl hydrochloride in 20 cases.

Conclusion

Bencyl hydrochloride, a new synthetic antispasmodic drug, has been administered by mouth to a variety of patients suffering from gastrointestinal complaints, such as functional bowel distress, peptic ulcer, chronic pancreatitis and gastroenteritis.

The usual dosage was 10 or 20 mg. three or four times daily, with or without 15 to 30 mg. of phenobarbital. The drug was well tolerated in 66 of 67 patients and was stopped only in one patient who was notorious for not tolerating other drugs. Bently hydrochloride appears to be more effective than the belladonna group of antispasmodics and offers the advantage of virtual freedom from psychoplegia, mydriasis and xerostomia.

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FIBROSARCOMA DEVELOPING IN HEAVILY IRRADIATED SKIN

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and

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The development of epidermoid carcinoma in areas of irradiated skin is unfortunately a fairly common occurrence. The development of sarcoma in such tissue is a rarity. This is a report of the only case of sarcoma following irradiation to come under our observation:

Mr. J. M. M., when first seen in 1929, was 58 years old. His history revealed that in August, 1927, an ulcerated crusted lesion of the lower lip of three months duration had been treated by application of a caustic paste. The lesion, never having completely healed, was surgically excised in January, 1929. Local recurrence occurred a few months later, and when first seen by one of us (C.B.S.) in December, 1929, a diagnosis of recurrent epidermoid carcinoma of the lower lip with possible metastatic cervical nodes was made. A radium mold was applied to his lip for 250 mg. hours and one gold tube inserted into the lip for 99 mg. hours. Gold tube implants were placed into nodes in the right neck for 396 mg. hours and in the left neck for 528 mg. hours. Following this he did very well, but because of persistent submental nodes an upper neck dissection was done in September, 1931. Only chronic inflammation of the nodes was found.

The patient was followed through the years, and several epitheliomas over his face and neck were treated successfully with x-ray. His lip continued free of disease until August 2, 1950, when he returned with an elevated, endured, crusted lesion about 1½ cm. in diameter in the radiation scar on the lower lip. Neck glands were negative. This lesion was excised

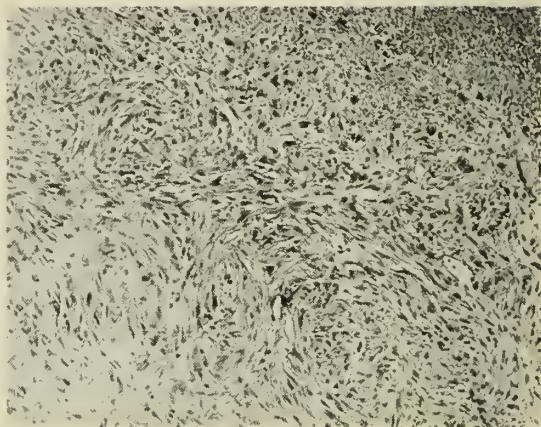


Fig. 1. Low power showing superficial infection and underlying sarcoma.

and the lip repaired. Pathologic report of fibrosarcoma in radiation scar was returned.

Sarcoma is a malignant tumor of connective tissue origin. Ewing¹ recognizes two classes of sarcomas which he considers distinct entities. The first are sarcomas resulting from chronic irritation. These present a comparatively simple spindle-cell structure; they are much less active, less atypical and less malignant. The second are sarcomas arising without signs or history of irritation. These Ewing hypothesizes grow from isolated embryonal cell groups.

Wilson and Brunschwig² report one case of sarcoma developing in tissue subjected to prolonged and repeated irradiation. They collected from literature in 1937 25 cases of sarcoma which had developed in areas of repeated irradiation. Nineteen of them were also subjected to chronic infection, either tuberculosis of the bone or lupus of the skin. Six cases, however, developed in the skin following treatment for cancer, hypertrichosis, eczema or following excessive exposure to fluoroscopy.

Stout³ reports numerous cases of irradiation fibromatosis. These he describes as tumor-like masses of proliferative scar tissue showing monstrous, atypical fibroblasts. He questions whether or not they should be called fibrosarcomas. However, he

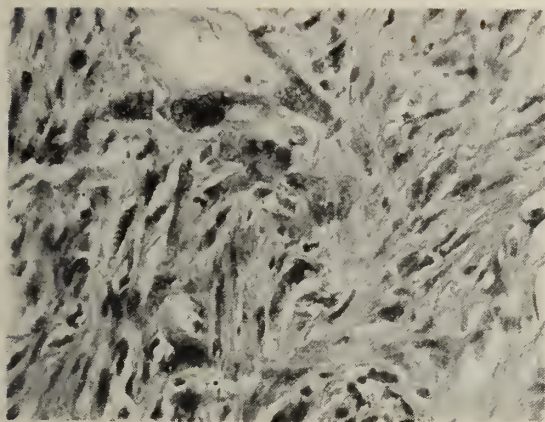


Fig. 2. High power showing large irregular deeply staining nuclei.

found frequent recurrences following attempted removal and four cases of definite metastases. He believes that undoubtedly malignant fibrosarcoma develops in irradiated skin, but that the occurrence is extremely rare. Fibrosarcoma has been found to follow various physical and chemical trauma, both incidental and experimental.

Sarcoma arising in irradiated bone is a different but interesting problem, and has been well presented by the group⁴ at Memorial Clinic who found 11 cases of sarcoma developing in irradiated benign giant cell tumors of the bone.

Buschke and Cautril⁵ feel that an important factor in bone as in other types of post-irradiation sarcoma seems to be repeated doses of x-ray extended over a long period of time. Single adequate doses seem unlikely to result in malignant change.

Summary

A case of fibrosarcoma, which developed in scar on the lip 20 years after radium therapy for squamous carcinoma, is presented.

Development of epidermoid carcinoma in radiation scar is common, whereas, sarcomatous change is rare.

Almost all cases reported of sarcomatous changes in irradiated tissue are associated

with chronic infections or prolonged repeated irradiation.

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INTERNAL DRAINAGE OF PANCREATIC CYSTS

The Utilization of the Roux Y Principle

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Atlanta

While it is generally agreed that surgical intervention for pancreatic cysts is mandatory, there is considerable divergence of opinion as to the type and technic of operation to be employed. There are three methods which may be utilized, i.e., total excision, drainage to the outside, and internal drainage through an anastomosis between the cyst and the gastrointestinal tract.

Obviously, total excision would offer the best possibility of cure but this method is one seldom achieved except in cases of small, true pancreatic cysts. In the majority of instances pseudocysts present technical hazards too great to allow complete excision. Marsupialization may offer satisfactory drainage and the technical aspects of the operation are not often difficult. The principle disadvantage of this method is the persistence of drainage and skin excoriation over long periods of time.

Internal drainage appears to eliminate some of the disadvantages of other methods. Many authors have described cystogastrostomy and cystojejunostomy, the anastomoses being accomplished without breaking the continuity of the gastrointestinal tract. This operation may allow food particles

From the Whitehead Department of Surgery, Emory University, and the Surgical Services, Grady Memorial Hospital, Atlanta.

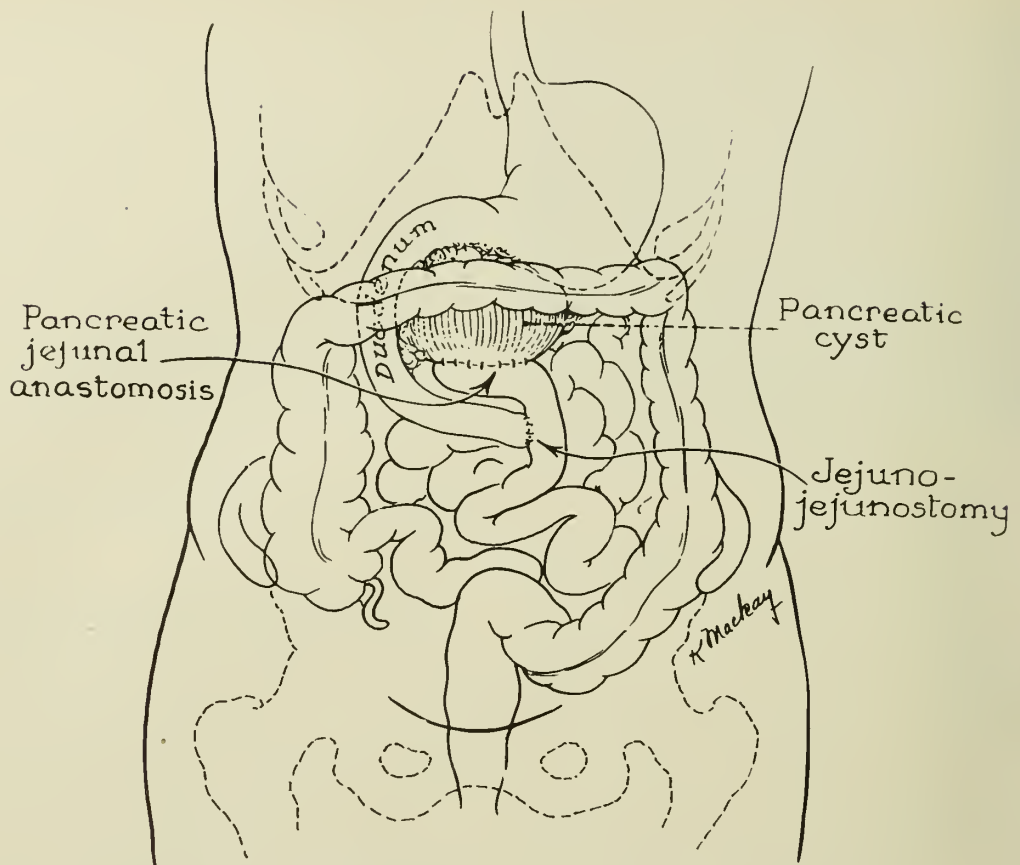


Fig. 1. Diagram illustrating the Roux principle for drainage of pancreatic cysts.

to enter the cyst resulting in stagation and infection.

The utilization of the Roux Y principle in performing cystojejunostomy should eliminate the potential danger of allowing intestinal contents to enter the cyst. The infrequency of case histories appearing in the literature warrants the study and report of an additional case.

CASE REPORT

J. S., a Negro laborer, aged 41, entered Grady Memorial Hospital on March 21, 1949, complaining of abdominal pain, nausea, vomiting, and obstipation of four days duration. He had experienced two similar episodes within the past three years. There was no history of abdominal trauma.

Examination revealed an acutely ill man with noticeable abdominal distension and considerable tenderness. An abdominal roentgenogram revealed distension of both large and small intestine, and numerous calcific areas in the region of the pancreas. Following decompression of the upper gastrointestinal tract with a Miller-Abbott tube, a firm, tender mass could be palpated in the epigastrium. A tentative diagnosis of chronic recurring pancreatitis with the formation of a pseudocyst was made. Treatment consisted of fluid and electrolyte replacement, whole blood transfusions, the administration of large doses of atropine and antibiotics, and the constant use of nasogastric

suction. While on this program the patient continued to run daily elevations of temperature, and the mass slowly increased in size.

An operation was performed under continuous spinal anesthesia on the ninth hospital day. The abdomen was entered through a transverse incision across the epigastrium. A pseudocyst of the pancreas measuring 15x15 cm. was found occupying the lesser peritoneal sac, displacing the stomach upward and the transverse colon downward. The cyst was opened through an incision in the transverse mesocolon which formed its inferior boundary. Biopsies were taken which subsequently demonstrated acute and chronic inflammatory reactions. The jejunum was divided about 20 cm. below the ligament of Treitz, and the cut end of the proximal segment was anastomosed to the side of the distal segment 10 cm. below the transection. The end of the distal jejunal segment was anastomosed to the cyst using the transverse mesocolon as the serosal layer of the cyst. The anastomosis was reinforced by suturing omental tabs about its circumference.

The postoperative course was uneventful until the tenth day when the patient developed phlebothrombosis of the lower extremities for which bilateral superficial femoral vein interruption was performed. The remainder of his hospital course was satisfactory and he was discharged on the 17th postoperative day.

This patient has been carefully followed for eighteen months. A small, non-tender mass is still palpable in his epigastrium, but his general health has been excellent and there have been no further symptoms referable to pancreatic disease.

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SALINE SOLUTION IN TREATMENT OF BURN SHOCK

The Surgery Study Section of the National Institutes of Health has recommended to the Surgeon General of the Public Health Service that the use of oral saline solutions be adopted as standard procedure in the treatment of shock due to burns and other injuries in the event of large-scale civilian catastrophe.

The recommendation followed action taken at the January 1950 meeting of the Surgery Study Section, when such treatment was approved in principle. Dr. Carl A. Moyer, a member of the Study Section, was designated at that time to prepare a memorandum suitable for submission to Mr. Norvin A. Kiefer, director, Health Resources Division (now Health Resources Office), National Security Resources Board.

Dr. Moyer's memorandum, which was submitted to Dr. Kiefer, February 15, 1950, reads as follows:

"Since the publication of the experimental work of Dr. Rosenthal, Dr. Collier, et al., orally administered salt solutions have been employed in the treatment of burns at the University of Michigan Hospital, Ann Arbor, Mich.; at the Wayne County General Hospital, Eloise, Mich.; and at Parkland Hospital, Dallas, Texas. Personal clinical experience, in the above-named hospitals, has convinced me that the orally administered salt solutions are valuable adjunctive agents in the treatment of shock incident to burns, fractures, peritonitis, and acute anaphylactoid reactions. Certain factors are important in governing the effectiveness of the oral administration of salt solutions. They are as follows:

"1. The composition of the salt solution: The most palatable salt solution is made by dissolving 3 to 4 Gm. of sodium chloride and 2 to 3 Gm. of sodium citrate in each liter of water. If sodium citrate is not available, ordinary baking soda may be substituted for it.

"2. The concentration of salt should not be in excess of 140 milliequivalents of sodium per liter. If the concentration is above this, vomiting and diarrhea became important complicating factors.

"3. Whenever profound peripheral circulatory collapse is present, the intravenous route of administration must be used until peripheral blood flow has been reestablished. The salt solutions that we have found most satisfactory for this purpose are Hartmann's solution (Lactate-Ringer's solution) or plasma. In addition to the salt solution or plasma intravenously, whole blood is given concurrently whenever peripheral circulatory collapse exists. This materially implements the effectiveness of salt solutions.

"The slightly hypotonic salt solution is the only drinking fluid permitted the injured indi-

vidual until the edema of the injured parts begin to subside. Certain exceptions to this rule have to be made during the hot weather of summer when it is sometimes necessary to permit the partaking of some non-salty water.

"As much as 10 L. of the hypotonic salt solution have been drunk in the 24-hour period by adults who have been severely burned. Since salt solution has been substituted for water, as a drinkable fluid, no burned person who has lived for longer than three hours after being admitted to the hospital has suffered from anuria. The 'early toxemia phase' of the burns has also failed to appear and the osmotic concentration of the plasma electrolytes has been well maintained.

"We feel that much more clinical observation and actual experimental work should be undertaken regarding the effectiveness of the basic principles of the supportive therapy of burns that have been so beautifully demonstrated by Dr. Rosenthal. It is obvious that the adoption of a more active program of investigation into the relative effectiveness of simple measures to combat shock would be of extreme importance to the Armed Forces and to the civilian population in the event of another war."

Because of the sharpened national emergency that developed during the summer of 1950, the Surgery Study Section, in approving Dr. Moyer's memorandum at its meeting on September 16, changed the last paragraph to read:

"While further clinical research concerning the effectiveness of oral salt solution in the treatment of burns and other injuries is certainly in order, there is already sufficient evidence to suggest that this form of treatment should be used in any large-scale disaster involving the civilian population."

The Surgery Study Section letter to the Surgeon General, dated September 16, 1950, reads as follows:

"It is my understanding that one of the functions of the Study Sections is to offer advice to the Surgeon General in fields of medicine lying within the special competence of the Study Section members. At the January 1950 meeting of the Surgery Study Section, there was considerable discussion concerning the use of oral saline solutions in the treatment of burns and other serious injuries. It was the consensus of the section at that time that, on the basis of the animal work which had been done by Dr. Rosenthal of the National Institutes of Health, and the clinical work which had been done by Dr. Carl A. Moyer, by the undersigned, and by others, the efficacy of such treatment had been definitely demonstrated and that, while there is need to stimulate additional research in this field, our present knowledge is sound enough so that action can be taken on this basis. Dr. Moyer was designated to

(Continued on Page 34)

THE JOURNAL

OF THE
MEDICAL ASSOCIATION OF GEORGIA

EDGAR D. SHANKS, M.D., Editor
478 Peachtree Street, N. E., Atlanta, Ga.

JANUARY, 1951

MEDICAL DUES, 1951

First, all dues—meaning your county society, state medical association and AMA—should be paid to the secretary of your county medical society.

If you do not know what your county dues are, then make inquiry of your local secretary. After having the information regarding county dues, add \$15 for the Medical Association of Georgia and \$25 for the American Medical Association.

Do you get the AMA journal with your annual dues? The answer is "yes". Your subscription to *The Journal of the American Medical Association* is included in your 1951 AMA dues.

All dues should be paid promptly to the secretary of your county medical society.

PROGRAM FOR EMERGENCY MEDICAL TRAINING IS OUTLINED

Only physicians highly trained can serve the national interest well, whether this be in a military or civil capacity, according to a report on medical education in time of national emergency.

This point was stressed by a joint committee representing the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges. The committee, in the report made public November 24, outlined a program designed "to profit from the experiences of World War II, to avoid a repetition of the mistakes made then and to attempt to prevent the occurrence of new errors."

"One of the hard lessons learned from the medical training program employed in World War II was that in the national interest demands for speed and quantity should never be permitted to interfere with quality," said the committee in its report, published in the November 25 *Journal of the A.M.A.*

"It is, consequently, especially important that no steps be taken at the beginning of the present emergency that will interfere with the

adequate training of physicians, either as medical students or as interns and residents, or with the supply of properly trained basic scientists."

The committee pointed out that such training requires an uninterrupted supply of students through college and into and through medical school and hospital. It nevertheless warned against acceleration, overcrowding of students or loss of faculty to the point where attention to the individual student would be diminished.

The statement also pointed out the importance of continued training of graduate students in the basic sciences to provide the personnel trained in these fields so urgently needed to staff the clinical departments of the medical schools and for the continuation of basic research in the medical sciences.

Instead of an accelerated program, the committee recommended that the academic year be extended in all schools to provide the additional training that will be needed by physicians to meet the special problems occurring in time of national emergency. Such an extension would permit more training in such subjects as the prevention and treatment of radiation injuries, bacteriologic warfare, chemical warfare, civilian disaster relief, public health, preventive medicine, industrial medicine, and injuries.

On the basis of the experience with the AST and V-12 programs in World War II, the committee also recommended against placing medical students in uniform or having them subsidized as a group by the government. Instead, it urged a program of government scholarships to be awarded, on the basis of economic need and demonstrated academic superiority, to students recommended by the medical schools. It also recommended government loans for students needing such assistance.

The committee also said "a plan should be devised which will define clearly the obligation of students who have been deferred for professional study to serve the government subsequent to completion of their training." Deferment, it stressed, should have as its only objective a later service in a needed capacity.

It also called upon medical schools to explore anew their resources for expanding teaching facilities without lowering quality.

The joint committee is composed of Drs. Stockton Kimball, Buffalo, chairman; Joseph C. Hinsey, New York; A. C. Bachmeyer, Chicago; Dean F. Smiley, Chicago, and George P. Berry, Boston, representing the Association of American Medical Colleges; Drs. Herman G. Weiskotten, Syracuse; Harvey B. Stone, Baltimore; Victor Johnson, Rochester, Minn., and Donald G. Anderson, Chicago, representing the Council on Medical Education and Hospitals of the A.M.A.

Liaison members are: Drs. Robert Hall, Chicago, secretary of the Council on National Emergency Medical Service of the A.M.A.;

Harold S. Diehl, Minneapolis, member of that council; B. R. Kirklin, Rochester, Minn., secretary of the Advisory Board for Medical Specialties, and David Ruhe, New York, director of the Medical Film Institute.

The report has been submitted to the National Advisory Committee on the Selection of Doctors, Dentists and Allied Specialists to the Selective Service System, and to the Health Resources Advisory Committee to the National Security Resources Board.

A.M.A. HEAD URGES DOCTORS TO BE ON ALERT IN NEW YEAR

It is incumbent on the medical profession to be especially alert in 1951, Dr. Elmer L. Henderson of Louisville, Ky., president of the American Medical Association, said December 29 in a New Year's message to doctors.

"The coming year will be one of new regulations, new restrictions, of growing economic problems and international crises," Dr. Henderson said. "We will be living under government controls necessary to the defense of our liberties—and we probably will be living under those controls for some years to come.

"All the more important, then, that we think straight and talk straight, and that we have a sound understanding of world and national affairs."

Dr. Henderson hailed to the statement of William L. Hutcheson, Indianapolis, general president of the United Brotherhood of Carpenters and Joiners of America, that he and his powerful union stand with doctors in opposing socialized medicine.

"Mr. Hutcheson's action will be a landmark in our continuing campaign against the evils of governmental control of medical care, and it opens to all of us a whole new field of work on the local level," he said. "It is a cheering note, and a challenge for 1951."

The recent appropriation of \$500,000 by the American Medical Association as the nucleus of a private fund to provide financial aid for medical schools was cited as a keynote for the coming year.

"The appropriation is solid, material proof that the medical profession is not just fighting against something, but is, and has been, doing positive things," Dr. Henderson said. "The advancement of medical education is not a new activity of the A.M.A. Annually, the association spends a quarter of a million dollars for that purpose through its Council on Medical Education and Hospitals.

"But the new fund will provide a vehicle for private financing of our medical schools and can end forever the arguments that Federal funds are their only salvation."

He called upon the doctors to extend to all communities the drive for similar contributions from private sources.

DIABETES DETECTION DRIVE REVEALS UNKNOWN SUFFERERS

Results of a two-year continuing diabetes detection program in Dayton, O.—during which time 69,159 persons were given free tests—are revealed in the November issue of the *Journal of the American Medical Association*.

The report was made public on the eve of the 1950 diabetes detection drive which will be held next week throughout the country under the sponsorship of the American Diabetes Association, Inc., New York. An estimated five million persons will be tested by local doctors and cooperating groups.

Cost of the nationwide program is met by local doctors themselves as a service to their communities and by voluntary contributions.

A breakdown of the figures of the Dayton drive, which was conducted by the diabetes detection committee appointed by the president of the Montgomery County (Ohio) Medical Society, shows that 4.7 per cent (2,991) of the total number examined had positive tests for sugar in the urine. Two thirds (2,024) of this suspected group subsequently submitted to blood sugar determinations which uncovered 148 previously unrecognized diabetic persons and confirmed diagnoses on 151 already known diabetics.

When a simple preliminary test shows sugar in the urine an additional blood test is necessary to determine whether or not the person actually has diabetes.

The diabetes detection committee began its activity in Dayton in December 1948 in cooperation with the first annual diabetes detection drive of the American Diabetes Association. Members of the committee were Drs. Thomas P. Sharkey, Paul Troup, Richard Miller, Herman C. Van Kirk and Homer H. Williams, and Robert Freeman, executive secretary of the Montgomery County Medical Society.

Widespread community support was enlisted for the campaign. Cooperating with the committee were: Dayton Chamber of Commerce, Metropolitan Health Council, Dayton School Board, city newspapers, radio and television stations, Parent-Teacher Associations, Dayton Pharmaceutical Association, Women's Auxiliary of the Montgomery County Medical Society, city officials, private and public laboratories and hospitals, industrial plants, community centers and recreational directors.

"In most other localities throughout the country," the committee explained, "the detection drive (1948) extended for a period of one week, but the program in Dayton has been a continuous one since it was launched.

"The results obtained in the Dayton drive have served to indicate that the mass testing of school children and industrial workers affords the simplest potential means for detecting un-

recognized diabetes under controlled conditions in a large segment of the population.

"The diabetes detection program in the industrial plants received high praise from both the employers and the employees. Each group believed that the other had contributed something of mutual benefit, and considerable good will was engendered.

"All employees with evidence of diabetes were encouraged to seek treatment from their family physicians, and they were notified that as long as their diabetes was controlled their prospects for continued employment and advancement were equivalent to those of other nondiabetic employees."

The report disclosed that a total of 21,094 industrial workers were tested, with 3.5 per cent having sugar-urine indications. Two thirds of this number submitted to blood sugar determinations. Newly discovered diabetic persons numbered 68. Thirty-three diagnoses on known diabetic patients were confirmed.

Approximately 1 in 20 of the 38,528 children tested in Dayton showed positive reactions for sugar. From the three fourths of this group who had further tests, 18 previously unknown cases were discovered. Two previously known diabetic children were also noted.

Commenting on the importance of diabetic detective work, Dr. William W. Bauer of Chicago, director of the A.M.A. Bureau of Health Education, said:

"Among serious diseases there are few more susceptible to specific medical management which, even in the absence of cure, prolongs life, increases efficiency, protects earning power, minimizes disability and adds to the joy of living. The insidious onset of the disease is the greatest handicap, and it is against this that the diabetes detection drives are aimed."

REPORT POSSIBLE HARDENING OF ARTERIES FROM CORTISONE, ACTH

The possibility that hardening of the arteries will result when cortisone and ACTH are administered to patients over a prolonged period of time is brought forth by three doctors associated with Mount Sinai Hospital, N. Y., who are studying the side-effects of the newly discovered drugs.

"The factor of prolonged therapy assumes a particular importance," said Drs. David Adlersberg, Louis Schaefer and Stanley R. Drachman, "because of the increased availability of these drugs. It may be expected that many patients with chronic diseases will now receive long courses of cortisone and ACTH therapy."

Writing in the November 11 issue of the *Journal of the American Medical Association* the doctors report that in 36 per cent (17 instances) of the 47 courses of the drugs administered, cholesterol was elevated to excessive

levels. This condition is called hypercholesteremia.

This is of extreme importance because medical researchers believe that a definite relationship exists between hypercholesteremia and hardening of the arteries.

The doctors further observed that the longer the treatment and the larger the dosage the more pronounced the condition (hypercholesteremia) became.

OUTLOOK OPTIMISTIC FOR PEPTIC ULCER SUFFERERS

Chances are good that a person suffering from peptic ulcer can live as long and as usefully as the average person if he follows a program laid down by a competent physician.

This encouraging note was sounded by Dr. Andrew C. Ivy and T. Arthur Turner in the November issue of *Today's Health*, published by the American Medical Association.

Dr. Ivy is vice-president of the University of Illinois in charge of the Chicago professional colleges. Mr. Turner is managing editor of a medical abstract service.

Cases requiring surgery and deaths caused by advanced process of the disease were found to be in the minority.

A peptic ulcer—and surveys indicate that 1 to 3 per cent of the population over 20 years of age is enduring peptic ulcer in its active state—is a sore on the inner wall of any area of the digestive tract which comes into contact with gastric juice. The cause of this condition is not known.

Indications from laboratory, clinic and social studies, however, are that "ulcer is much commoner in some occupations than others and is apparently related to irregular living habits, prolonged or chronic nervous tension, anxiety and fatigue," the authors reported.

"In animals (experimental), ulcers have been caused by diets deficient in vitamins, by interference with the endocrine glands, by local allergic reactions, by injection of certain drugs, by mechanical injury and other means."

Medical science is concerned not only with the cause of the sickness but with the further problem of why actual healing of the ulcer is delayed.

According to the article, many acute ulcers in human beings heal spontaneously after a short period of unexplained discomfort, but many, on the other hand, do not. Persons seeking the attention of a doctor are usually chronic sufferers.

"Regardless of the cause," the survey concludes, "both laboratory investigations and practical clinical experience have given the doctor information that makes it possible for him to treat a large majority of patients with success—provided they cooperate.

"Even if he does not know for sure that

certain habits of eating, (such as improper chewing of food), drinking (alcohol and coffee, for example) and daily living caused the ulcer in the first place, he does know that they will aggravate it and delay healing."

CALLS FOR COOPERATION IN OCCUPATIONAL CANCER CONTROL

With the knowledge that about 200 chemicals are possible cancer producing substances, the director of the National Cancer Institute, Bethesda, Md., recently called for the joint efforts of industrial and labor organizations combined with local, private and state health agencies to aid in the further discovery and control of these agents.

Research needed to solve the problem of environmental and occupational cancer presents a challenge of "tremendous proportions," said Dr. John R. Heller, Jr., in *Archives of Industrial Hygiene and Occupational Medicine*, published by the American Medical Association.

More research into the background and case histories of cancer patients, laboratory testing of suspected cancer-producing agents, follow-up studies of exposed workers and studies of safety procedures and preventive measures in plants where such substances are handled are necessary, believes Dr. Heller, to "solve the mystery" of environmental and occupational cancer.

Credit for making "remarkable progress" in meeting the hazard with practical solutions whenever possible is attributed, by Dr. Heller, to industry itself. He continued:

"As we increase our understanding of all the factors involved, changes in industrial operation may be necessary in some cases in order to protect employees and the public. It is important to emphasize, however, that more knowledge than we now have must be acquired before such action would be justified in many instances.

"The results of environmental, and especially occupational, cancer investigations, whether these deal with already known or with new hazards, should be widely disseminated.

"Our common experience in the control of other public health hazards has shown us that the effectiveness of control measures runs parallel to frank and open acknowledgement when the facts are known."

Dr. Heller pointed out that "Research done on laboratory animals can serve to alert us to the chemicals which may possess potential cancerigenic properties in human subjects. Considering that a danger of the chemical cancerigens lies in the slow, almost unnoticeable harm that comes from contact with them, it might be wise from a preventive point of view to consider all chemical agents which have elicited cancers in animals as having the potential properties for producing cancer in the human organism."

STUDENT DELEGATES FROM MEDICAL SCHOOLS MEET

Student delegates from 48 medical schools throughout the United States with a total enrollment of 15,855 at a meeting in Chicago December 28-29 organized the Student American Medical Association.

The organization will have as its objectives: (1) the advancement of medicine; (2) contribution to the welfare and education of medical students; (3) familiarization of its members with the purposes and ideals of the medical profession, and (4) the preparation of its members to meet the social, moral and ethical obligations of the profession.

Warren R. Mullen of Jackson, Mich., a student at the University of Michigan Medical School, Ann Arbor, was elected president; Harry W. Sandberg of Moline, Ill., a student at the University of Illinois College of Medicine, Chicago, vice president; and David Buchanan of Huron, S. D., a student at the University of South Dakota School of Medical Sciences, Vermillion, treasurer. Leo Brown of Harrisburg, Pa., is the executive secretary and will make his headquarters at the American Medical Association in Chicago.

Elected as members of the executive council were: Bill Davenport, Clinton, Ark., (University of Arkansas School of Medicine, Little Rock); Herbert Sperling, Great Neck, Long Island, N. Y., (Boston University School of Medicine); John W. Looper (Medical College of Georgia, Augusta); Donald J. Brugger, Alliance, O., (Ohio State University College of Medicine, Columbus); J. Allan Henderson, Hood River, Ore., (University of Oregon Medical School, Portland); Charles Wilson, (University of Texas School of Medicine, Galveston); Howard J. Christian, Newton, Mass., (Tufts College Medical School, Boston).

The association will be made up of academic societies in medical schools of the United States approved by the Council on Medical Education and Hospitals of the American Medical Association. Each society, not more than one at any school, must have a membership of at least one-fourth of the students, or 35 students, whichever is the smaller.

Each society shall have equal rights and equal representation in the S.A.M.A. house of delegates, which will determine the policies of the association. Academic societies shall determine the qualifications of their own membership but no society may refuse membership on the basis of race, religion, color or sex. Interns may be admitted to membership at the discretion of the local society.

The house of delegates will be composed of one representative from each constituent society. It will determine the policies of the association. There will be three elective offices—president, vice president and treasurer.

Executive authority will reside in an executive council composed of the officers, seven student councilors (no two or more from the same academic society) and three senior councilors. The 10 students on the council will be the elected representatives of the students. Three senior councilors will be named by the A.M.A., which also will provide an executive secretary and headquarters in Chicago. The executive secretary, who will coordinate the activities of the student organization on a national level, shall have no vote in the council.

An advisory committee to each constituent society will be composed of the dean of the school, or his appointed representative; two faculty members elected by the students, a county medical society representative and a state medical society representative.

The student house of delegates has named its president and vice president as representatives to the American Medical Association House of Delegates. A change in the constitution of the A.M.A. to provide such representation is expected to become effective at the annual meeting in Atlantic City in June.

The executive council of the S.A.M.A. with the approval of its house of delegates may raise funds by levying annual dues on each academic society on the basis of the membership as of April 1. the amount to be specified by the by-laws of the house of delegates. This was fixed initially at \$1 per student membership. Funds also may be raised through publications.

Until such time as the association decides to issue its own publication, space will be made available to the S.A.M.A. in the *Journal of the American Medical Association*.

CALL NATIONAL CONFERENCE TO STUDY CHRONIC ILLNESS

The first national conference of the newly organized national Commission on Chronic Illness will be held in Chicago at the Edgewater Beach Hotel on March 12, 13 and 14, it was announced.

The aim of the conference, according to Dr. Morton L. Levin, Chicago, staff director of the commission, is to determine how the chronic disease problem—the nation's No. 1 health problem—can be attacked at its roots through prevention.

Present day scientific knowledge regarding prevention and early detection of major chronic disease will be reviewed at the meeting. Some of the major chronic diseases to be studied are: cancer, heart disease, arthritis, rheumatism, diabetes, blindness, deafness, tuberculosis, syphilis, and neuro-muscular disorders such as poliomyelitis, multiple sclerosis, cerebral palsy and epilepsy.

Emotional factors in chronic disease; malnutrition, including obesity, as causes of chronic

disease; heredity, and occupational causes also will be considered, said Dr. Levin.

Practical application of this existing knowledge to community case-finding and prevention programs will be considered by the conferees in five working committees: evaluation of scientific data, prevention in medical practice, professional information and training, community organization and services, and public information.

The national Commission on Chronic Illness was founded in 1949 by the American Medical Association, American Hospital Association, American Public Health Association and the American Public Welfare Association. It is now an independent national agency studying the common denominators—the similar medical-social-economic problems presented by various forms of chronic illness and disability.

Co-sponsors of the national conference on preventive aspects are the National Health Council and the U. S. Public Health Service.

Delegates to the conference will represent national voluntary and official agencies, professional organizations and individuals working in all fields related to the problems of chronic illness.

The conference is being planned by a steering committee made up of the following:

Drs. Lester Breslow, San Francisco; I. Jay Brightman, Albany, N. Y.; A. L. Chapman, Daniel Blain, Washington; Ward Darley, Denver; Vlado Getting, Boston; Thomas Parran, Pittsburgh; Edward S. Rogers, Berkeley, Calif.; Milton Terris, C. J. Van Slyke, Bethesda, Md.; Ernest B. Howard, Andrew C. Ivy, Chicago; Charles Cameron, Thomas D. Dublin, John W. Ferree, T. Duckett Jones, Brewster Miller, James E. Perkins, Hart Edgar Van Riper, New York, and also Miss Ruth Hubbard, R.N., Philadelphia; George Cooley, Miss Loula Dunn, Peter G. Meek, Miss Edna Nicholson, Maurice J. Norby, Chicago.

Mrs. Lucille Smith, Washington, is associate director of the conference. Leonard W. Mayo, New York, chairman of the Commission on Chronic Illness, will preside.

Future conferences will be called by the commission to consider the care and rehabilitation aspects of long-term illness.

1951 DUES

The 1951 dues to the Medical Association of Georgia will be \$15.00 and the 1951 dues to the American Medical Association will be \$25.00.

The *State Journal* and the *American Medical Association Journal* will be included in the 1951 dues.

The Medical Association of Georgia will hold its next annual session at the Bon Air Hotel, Augusta, April 17-20, 1951.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

DIAGNOSIS AND TREATMENT OF GRANULOMA INGUINALE

RUDOLPH W. JONES, JR., M.D.
Macon

Although granuloma inguinale is a relatively uncommon venereal disease, it may produce considerable destruction of the genitalia or other tissues and has at times resulted in death. Prompt diagnosis and treatment of this infection, however, will prevent serious damage as well as the complications caused by lymphatic obstruction or hematogenous spread. The recent development of newer antibiotics now provides an effective method for the ambulatory treatment of granuloma inguinale.

Clinical Manifestations

The early lesion of granuloma inguinale is a small, sharply circumscribed, non-tender ulceration with a red granular base and elevated indurated edges. The lesion is usually found about the genitalia, particularly in the inguinal area. The ulcers slowly enlarge and coalesce and may result in marked deformity or destruction of the tissues. Obstruction to lymphatic drainage may produce elephantiasis. In the presence of secondary infection, the lesion may have a foul-smelling, purulent discharge. On rare occasions dissemination of the infection by the blood stream has resulted in arthritis and osteomyelitis.

Diagnosis

The etiologic agent of this infection is now known to be a non-motile, Gram negative bacillus—*Donovania Granulomatis*. It is also known as the Donovan body and is most frequently seen as an encapsulated, bipolar-stained organism occurring within large mononuclear cells. The diagnosis is usually made by the demonstration of the organism in either impression smear or in biopsy specimens taken from the ulcerative lesion. Donovan bodies are usually numerous in early lesions, but may be difficult to find in chronic or healing lesions. In the absence of typical Donovan bodies, the diagnosis may be made by histologic examination. The morphologic picture is that of a richly vascularized, granulation tissue with marked inflammatory cell infiltration, small microabscess formation and numerous large mononuclear cells with vacuolated cytoplasm. Although the organism can be cultured in artificial media containing egg yolk, this procedure is not generally employed except for research purposes. Skin tests and complement fixation tests, employing antigens made from cultures of the

organisms have been developed, but have not become clinically useful.

Treatment

The older methods of therapy with anti-mony compounds has been replaced by new antibiotic agents. Streptomycin was the first antibiotic found to be effective in this infection. Greenblatt and his coworkers² noted relapses in only 10 per cent of their cases following streptomycin therapy, and half of these responded satisfactorily to a second course of therapy. The relapses usually occurred within four months after therapy. No recurrences appeared in those patients who remained well for six months following completion of therapy. The dosages of streptomycin usually employed are 4 Gm. daily for 7 to 14 days, but smaller doses may be employed in patients with early lesions. Streptomycin therapy does not necessarily require hospitalization, since ambulatory treatment with single daily injections of this drug have been found to be effective³.

The use of streptomycin in this disease has been largely replaced by oral therapy with newer antibiotics. Oral administration of aureomycin has been found by Hill and his associates⁴ to be highly effective in granuloma inguinale. Although these investigators administered 1 Gm. daily for a prolonged period, it appears that dosages of 2 to 4 Gm. daily for a total of 20 to 40 Gm. will also produce good results. The time required for healing depends upon the extensiveness of the lesion and the presence of complications. In general, 2 to 4 weeks were required for complete healing of simple ulcerations.

Chloromycetin has also been found to be effective in the treatment of this disease. A total dosage of 20 grams of chloromycetin, given during a 5 to 10-day period, is reported to produce rapid healing⁵. Sufficient data have not yet been accumulated to enable a comparison of the relative effectiveness of aureomycin and chloromycetin. Thus far, no case resistant to aureomycin or chloromycetin therapy have been reported.

REPORT OF CASES

Case 1. E.L., a 25-year-old colored female was found to have a granulating lesion, of unknown duration, on the vulva. The lesion consisted of a 4x5 cm. ulceration on the left labia and fourchette with a friable, granulating base and indurated, circumscribed border. A biopsy of the lesion revealed the histologic appearance of granuloma inguinale, as well as typical Donovan bodies located within large mononuclear cells. The patient was given 1 gram of terramycin every 6 hours for 10 days. By the tenth day of therapy, the ulcer was completely epithelialized. Two months later, only a small scar formation was evident.

Case 2. M. J., a 39-year-old colored female was found to have a 3x4 cm. granulomatous ulceration on the posterior commissure of the vulva. This lesion consisted of a superficial punched-out ulceration with

From the Clinic for Genitoinfectious Diseases, Grady Memorial Hospital, Emory University School of Medicine, and the Georgia Department of Public Health.

elevated, indurated edges and a purulent exudate covering the base. A 3x5 cm. tender node was present in the right inguinal region. Biopsy of the lesion revealed the histologic changes of granuloma inguinale as well as presence of Donovan bodies. The patient was given 0.5 gram of terramycin every 6 hours for 10 days. Complete healing of the lesion occurred within 2 weeks. Five months later, only a slight scar was evident.

Similar good results with terramycin have been reported by Hendricks and his associates⁶. Using a dosage of 60 mg. per kilogram of body weight, they noted that the Donovan bodies disappeared from the lesions within 3 days and excellent healing occurred.

Comment

Emphasis must be placed upon the early recognition of the lesions of granuloma inguinale by means of either impression smears (stained by Wright's method) or by examination of biopsy specimens. Rapid healing of the lesions of granuloma inguinale can be achieved with the newer antibiotics. It has not yet been established which of these drugs is the treatment of choice. All are relatively non-toxic and can be administered orally without serious toxic manifestations. Further experience with these agents will be necessary to determine which is the most useful. At the present time the effective dosages of aureomycin, chloromycetin, and terramycin are 2 to 4 grams daily for a total of 20 to 40 grams over a period of approximately 10 days.

Summary

1. The early diagnosis of granuloma inguinale can usually be made by Wright's stain of impression smears from the lesions or by histologic examination of biopsy specimens.

2. Rapid healing of the lesions can be achieved by oral administration of either aureomycin, chloromycetin or terramycin. Sufficient data are not available at present to determine which of these agents is the treatment of choice.

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SALINE SOLUTION IN TREATMENT OF BURN SHOCK

(Continued from Page 27)

draft a short memorandum expressing our point of view on this subject. Such a memorandum was prepared and furnished to Dr. Norvin C. Kiefer, director, Health Resources Division, National Security Resources Board, on February 15, 1950. A copy of Dr. Moyer's memorandum is attached.

"In view of the more acute national emer-

gency that has developed since Dr. Moyer wrote this memorandum, the Study Section, at its meeting on September 16, 1950, voted to recommend that the principles of treatment outlined in his memorandum be adopted for widespread use in any large-scale disaster involving the civilian population. Because of the present emergency situation, we have modified the last paragraph of Dr. Moyer's memorandum to read, 'While further clinical research concerning the effectiveness of oral salt solution in the treatment of burns and other injuries is certainly in order, there is already sufficient evidence to suggest that this form of treatment should be used in any large-scale disaster involving the civilian population.'

"You are at liberty to transmit this recommendation of the Surgery Study Section to the National Security Resources Board or to other proper agencies, and, if you see fit, to publish it. We feel strongly that it is important for the medical profession of the country and for those planning for the handling of potential disasters to be informed of the value of this simple and easily carried out form of treatment."

The letter was signed by Frederick A. Collier, M.D., University of Michigan, chairman of the Surgery Study Section. Members of the Study Section, in addition to Dr. Collier, are: Dr. Claude S. Beck, professor of neurosurgery, Western Reserve University; Dr. Loren R. Chandler, dean, Stanford University Medical School; Dr. Lester R. Dragstedt, professor of surgery, University of Chicago; Dr. Daniel C. Elkins, professor of surgery, Emory University; Dr. Carl A. Moyer, dean and professor of surgery, Southwestern Medical School, University of Texas; Dr. Harris B. Shumacker, Jr., professor of surgery, Indiana University Medical Center; Dr. Owen H. Wangenstein, professor of surgery, University of Minnesota; Dr. Allen O. Whipple, clinical director, Memorial Hospital, New York City; Dr. H. L. Skinner, chief of surgery, Staten Island Marine Hospital; Dr. Henry Beecher, professor of anesthesiology, Harvard University Medical School; Dr. J. Gordon Lee, chief of surgery, Mount Alto Hospital, Washington, D. C.; Dr. Howard R. Lawrence, chief of surgery, Francis E. Warren Air Force Base Hospital, Wyoming; and Dr. G. Halsey Hunt, chief, Division of Hospitals, Public Health Service.

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THE DRAFT OF DOCTORS

During World War II, the Medical Association of Georgia set up a Procurement and Assignment Committee to determine what doctors could be more useful in uniform than in their accustomed fields. This committee consisted of Drs. W. A. Selman, John B. Fitts, and Edgar D. Shanks.

In August this year, the Council of the Association decided that in the present emergency a similar committee would be needed, and they elected to this committee Dr. W. A. Selman, chairman. Dr. L. Minor Blackford, alternate; Dr. A. O. Linch, Dr. John W. Turner, alternate, and Dr. Edgar D. Shanks, Dr. Spencer Kirkland, alternate.

About the same time, the Medical Society of Georgia independently made a review of the doctors in Chatham County. They set up a point system similar to the one used in bringing Army personnel back to this country after World War II: points were allowed for age, military service, and dependents, and were deducted for every month in the service of the country. They submitted their roster to the committee. This system appealed to the State Committee and at first they planned to apply it to the whole State.

In September, the 81st Congress passed the "Doctor Draft Law" (Public Law 779) and it was signed by the President on the 9th, and published in the *Journal of the American Medical Association* of the 30th, and in the October number of *The Journal*.

This law authorized the President to require special registration of "male persons" who are doctors, dentists, or veterinarians and who have not "reached the age of fifty at the time of registration", exclusive of those holding commissions in the Reserves. Such men "shall be liable for induction for not to exceed twenty-one months of service in the Armed Forces".

These "male persons" were divided into four categories and the first were required to register in October.

The law further established a National Advisory Committee to the Selective Service System. The chairman of this committee appointed Dr. Carter Smith chairman of the Medical Advisory Committee for the State of Georgia, with Dr. Tom F. Sellers to help him, Dr. Steve A. Garrett to look after the dentists, and Dr. Charles C. Rife the veterinarians. Dr. Smith was authorized to nominate his associates. He selected Dr. A. O. Linch, Dr. David Henry Poer, Dr. Cyrus W. Strickler, Jr., and Dr. L. Minor Blackford. These appointments have since been confirmed by Washington. This committee has appointed several committees to advise it.

This State Committee is charged with the responsibility of advising the Selective Service System what "male persons" should be deferred at the time they

are called up for active duty, or excused altogether. It has recently been directed to consider only the importance of these persons in their home communities. "All other reasons given for deferment will be given consideration by the applicant's draft board."

It is understood that the responsibilities of the committee will be increased before long to consider deferment of Reserve Officers.

COMMUNICATIONS

Medical College of Georgia,
Augusta, Ga., Dec. 26, 1950.

Dr. E. D. Shanks, Editor of the Journal
Medical Association of Georgia,
478 Peachtree Street, N. E.
Atlanta, Georgia.

My dear Ed:

Because of many inquiries concerning the matter, I should like to have you insert a notice in the *Journal* to the effect that our Department of Thoracic Surgery is at present in the charge of Dr. Robert G. Ellison and that the department is being conducted as usual pending Dr. Robert C. Major's return. Doctor Ellison, after a long period of training in general surgery, specialized over a period of several years in thoracic surgery under the supervision of Doctor Major.

Thanking you for your efforts in getting this news across to the profession in the state, and with best wishes, I remain

Very sincerely yours,
G. LOMBARD KELLY, M.D.,
President.

P.S. This concerns us principally with reference to the Medical State Aid service which brings in many patients for thoracic surgery.—GLK.

* * *

Atlanta, Ga., Dec. 26, 1950.

Dr. Edgar D. Shanks,
The Journal of the Medical Association of Georgia,
478 Peachtree St., N. E.,
Atlanta 3, Ga.

Dear Dr. Shanks:

I would appreciate your having a notice carried in the next issue of the *Journal* asking the doctors of the state to furnish me any information they might have, which they think could be incorporated in the medical history of Georgia. Anything of interest about any doctor from the beginning of Georgia up to this present time.

By the time of the annual state meeting, I hope to have some really worthwhile report to make; I am putting all the available time I have to the task of compiling and consolidating the material which is being sent in.

With kindest regards to you, I am,

Very truly yours,
J. CALVIN WEAVER, M.D.

* * *

January 4, 1951.

The Milledgeville State Hospital announces a series of lectures and demonstrations by Dr. J. L. Moreno, first psychiatrist at the Beacon Hill Sanitarium at Beacon, N. Y., beginning Friday afternoon, January 19, 1951 and ending Sunday noon, January 20, 1951. All psychiatrists and those interested in psychology, psychiatry, and any particular group therapy and psychiatry are invited to attend these lectures and demonstrations.

Dr. Moreno is the foremost exponent of this type of group therapy in the United States. In fact, he has pioneered in this work, starting group psychotherapy with children and deviates in Vienna in 1911. He was graduated from Vienna University with an M.D. degree in 1917. He opened a Therapeutic Theatre in Vienna in 1923. He came to America and was licensed to practice medicine in New York State in 1927. He opened the Therapeutic Theatre in New York City

in 1929. He initiated the first national conference on Group Psychotherapy held at the meeting of the American Psychiatric Association in Philadelphia in 1932. He directed the Sociometric study of the community in Hudson, N. Y., in 1932. He also pioneered in therapeutic motion pictures—demonstrated a film "Spontaneity Training," at the meeting of the American Psychiatric Association, Washington, D. C., May 1935.

He opened the Beacon Hill Sanitarium licensed by the Department of Mental Hygiene in 1936. In 1937 he opened a Theatre of Psychodrama at Beacon. He assisted in the establishment of the Theatre of Psychodrama at St. Elizabeth's Hospital, Washington, D. C., in 1940. He founded "Sociometry", first Journal of Inter-personal Relations in 1937 and now in its thirteenth year of publication. He founded the Sociometric Institute in New York in 1942. Later on in 1942 he opened a Theatre of Psychodrama, in New York. He founded "Group Psychotherapy", Journal of Sociopsychopathology and Sociatry, in 1947.

Dr. Moreno is a member of the American Psychiatric Association (Fellow), American Medical Association, Medical Society of the State of New York, Society for Group Psychotherapy and Psychodrama. He holds a teaching position in New School of Social Research, and at Teachers College, Columbia University. He has published a number of papers in regard to Psychodrama and Group Psychotherapy.

T. G. PEACOCK, M.D., Superintendent,
Milledgeville State Hospital.

NEWS ITEMS

The Appling County Medical Society held its monthly meeting at Baxley, November 14. Program: Dr. Sage Harper, Douglas, Councilor of the Eighth District Medical Society discussed "Voluntary Health Insurance." Dr. J. T. Holt, Baxley, read a paper entitled "Coronary Thrombosis." The society plans to sponsor a moving picture, "To Your Health," at an early date. New officers are: Dr. J. B. Brown, Jr., president; Dr. W. D. Branch, vice president, and Dr. J. T. Holt, secretary-treasurer. Dr. H. C. McCrackin was elected chief of the Appling General Hospital staff. The hospital is expected to open at an early date. Dr. J. T. Holt, secretary-treasurer.

The Atlanta Graduate Medical Assembly will be held February 5, 6 and 7, under the sponsorship of the Fulton County Medical Society and the Fifth District Medical Society at the Municipal Auditorium Annex, Atlanta. The Assembly will offer for the second time color television demonstrations. Operations and medical clinics at Grady Memorial Hospital will be viewed in full color. Dr. A. H. Letton, chairman of arrangements for the color television, said a wide variety of surgical technics would be televised. Dr. L. Minor Blackford, chairman of the general committee for the Medical Assembly, said some of the nation's most outstanding physicians will speak. They will cover subjects ranging from the new antibiotics to neurosurgery. For full information write to Dr. L. Minor Blackford, 104 Ponce de Leon Ave., N. E., Atlanta.

Dr. W. W. Brown, Athens, Commissioner of Health in Clarke County, has been officially commissioned as Local Registrar for Georgia Militia District No. 220, of the State Vital Statistics Registrar. The announcement was recently made by the Georgia Department of Public Health and the new appointment makes Dr. Brown Local Registrar for the entire county of Clarke.

The Carroll-Douglas-Haralson Medical Society held its monthly meeting at Rock Inn, Douglasville, November 6. Dr. T. C. Davison, Atlanta, president of the American Goiter Association was guest speaker. Dr. Davison is one of the best authorities in his field of

medicine. Also present was Dr. Hal M. Davison, Atlanta, president of the Fulton County Medical Society and past president of the Association of Allergy, a brother of Dr. T. C. Davison.

Dr. Rolla Eugene Dyer, Atlanta, Director of Research at the Robert Winship Clinic, Emory University School of Medicine, has been awarded the Sedgwick Memorial Medal for 1950 for "distinguished service in public health." Dr. Dyer, who recently served as Director of the National Institutes of Health, Bethesda, Md., was honored for his "scientific accomplishments in the field of microbiological research and for the administration of the Institutes of Health during the war and postwar years."

Commander Monroe J. Epting, prominent Savannah physician on active duty with the U. S. Navy, has been transferred from the U. S. Marine Recruiting Depot at Parris Island, S. C., to the U. S. Naval Hospital, Jacksonville, Fla. Commander Epting is a veteran of the last war and after his discharge he returned to Savannah to resume his practice. He had been out of the service about three years before he was called back into active service with the U. S. Navy. He was a commanding officer at the U. S. Naval Reserve Armory, Savannah before re-entering the service several months ago.

The Fulton County Medical Society held its semi-monthly dinner meeting at the Academy of Medicine, Atlanta, December 21. Program: Annual meeting. President's Address, Dr. A. O. Linch; Annual Reports by committee chairmen; Memorial Service by Dr. Lester A. Brown. Election of officers: Dr. Jack C. Norris, President-elect; Dr. William A. Smith, Vice-president; Dr. Tully T. Blalock, Secretary-Treasurer; Dr. J. D. Martin, Jr. and Dr. B. L. Shackelford, members of the Board of Trustees; and Dr. Vernon Powell, member of Judicial Council.

The Crawford W. Long Memorial staff dinner meeting was held in the dining room of the hospital, Atlanta, January 9. Program: "Aortic Embolism. Case Presentation", Dr. Stacy C. Howell. Discussion: Dr. Lamont Henry and Dr. Hilton Wall. Pediatric and Obstetrics Section: "Fetal Mortality Statistics", Dr. John S. Walker. Medical Section: "Clinical Aspects Dextran", Dr. Walter Bloom. Surgical Section: "Gastrointestinal Malignancy—Motion Picture". General Practitioners: "Diagnosis and Treatment of Syphilis Today", Dr. Albert Heyman.

The Georgia Medical Society held its anniversary meeting at 612 Drayton Street, Savannah, December 12. Election of officers and final reports. Dr. Sam Youngblood, Jr., Secretary.

Dr. Lee Howard, Jr., Savannah physician, recently passed the qualifying examinations as a diplomat of the American Board of Pathologists. A graduate of Duke University School of Medicine, Durham, N. C., in the class of 1943. Dr. Howard is now medical director of the Red Cross Regional Blood Center. He is also associated with his father, Dr. Lee Howard, in the practice of pathology.

Dr. Harvey Howell, Cartersville physician, warned of socialization evils in medicine in an address before the Cartersville Jaycees on November 16. Dr. Howell branded compulsory health and accident insurance as a "step toward socialism", but praised voluntary health and accident insurance plans.

Dr. James A. Johnson, Jr., Manchester physician, and Dr. G. Lombard Kelly, Augusta, president of the Medical College of Georgia, were elected members of the executive board for the Better Health Confer-

ence held in Atlanta in connection with the seventh Georgia Citizens Conference. Chairman of the Board is Mrs. Shelley C. Davis, Atlanta. The executive board directs the program of the Health Division of the Georgia Citizens Council which is developing Regional Better Health Conferences throughout Georgia. The purpose of these meetings is to stimulate interest among citizens in state and local health problems.

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Dr. G. Lombard Kelly, Augusta physician and president of the Medical College of Georgia, told the Augusta Kiwanis Club recently that plans for a great medical center to be built around the Medical College of Georgia, Augusta, are now beginning to move forward in an address at the luncheon meeting at the Richmond Hotel. "There is every reason to believe," Dr. Kelly said, "that these plans will continue to gain momentum." Dr. Kelly reviewed briefly some of the interesting points in the development of improved medical education opportunities in this country. He emphasized the fact that American medical education is now the best in the world and pointed to the further fact that Augusta's medical college has always been in the forefront of progress along these lines. Augusta, Dr. Kelly said, is a logical place for the creation of a great medical center and the proposed plans will make it possible to provide better care for the sick people in Georgia. It will also mean expanded educational opportunities for the young doctors in Georgia.

* * *

The Laurens County Medical Society held its annual dinner meeting at the Country Club, Dublin, December 15. Dr. Jerry P. Woodhall, Macon surgeon, was guest speaker. His subject was "Venous Thrombosis." Announcement was made that the Sixth District Medical Society will hold its semiannual meeting in Dublin next June. The following officers were re-elected for the year 1951: Dr. M. Fernan-Nunez, president; Dr. Charles A. Hodges, vice president, and Dr. O. H. Cheek, secretary-treasurer.

* * *

Dr. Elisabeth Martin, Atlanta, announces that beginning January 1, Dr. Kathleen Wickman will replace her in her office at 56 Fifth Street, N. E., Atlanta. Dr. Martin has practiced obstetrics and gynecology in Atlanta for six years and will begin two years training in obstetrics and gynecology at Gallinger Municipal Hospital, Washington, D. C. Dr. Wickman received her training at the Margaret Hague Hospital, New York City. She is the wife of Dr. Jack White, surgical resident at Lawson VA Hospital, Chamblee. Dr. Martin plans to resume her private practice in Atlanta in January, 1953.

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Dr. Joseph C. Massee, Atlanta physician, has been re-elected chairman of the Health Division of the Community Planning Council, according to Herman Heyman, council president. Dr. Walter W. Daniel, Atlanta obstetrician, was named co-chairman. Dr. Massee and Dr. Daniel are past presidents of the Fulton County Medical Society. Other board members are Dr. C. C. Aven, Dr. J. F. Hackney, Dr. R. W. McGee and Dr. T. O. Vinson. The Health Division, composed of representatives of organizations engaged in health work, serves as a central medium for coordination and planning of health and hospital services in Fulton and DeKalb counties.

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The Medical College of Georgia, Augusta, conducted a refresher course in obstetrics sponsored by the Maternal and Child Health Divisions of the state departments of health of Georgia, Florida, South Carolina and under the direction of Dr. Richard C. Torpin. Georgia physicians participating on the program were: Dr. George A. Williams, Dr. J. B. Cross, Dr. E. L. Griffin, Dr. Guy C. Hewell, and Dr. J. B.

Varner, all of Atlanta; Dr. Robert B. Greenblatt, Augusta; Dr. H. F. Sharpley, Savannah. One of the highlights of the program was a lecture by Dr. Richard C. Torpin on "The Physiology of Labor." Dr. Perry P. Volpitta, Augusta, talked on "Analgesia, Anesthesia, and Amnesia in Labor."

* * *

The Medical College of Georgia, Augusta, had two faculty members named as leaders of a conference on the opportunities and possibilities of old age recently held at the University of Georgia, Athens. They were Dr. William J. Cranston and Dr. Harry T. Harper, Jr., both professors of clinical medicine. The conference, technically called "Forums on Gerontology," was attended by many of the state's directors of programs for older people as well as by older people themselves looking for answers to some of their problems.

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The National Malaria Society, the American Society of Tropical Medicine and the American Academy of Tropical Medicine held a four-day joint convention at the Hotel DeSoto, Savannah, November 6-9. Dr. A. G. Van Veen, of the United Nations, was one of the distinguished speakers on the program. Of particular importance to the convention was the symposium on "Nationwide Eradication Projects in the Americas." The Savannah committee on arrangements were Dr. Julian K. Quattlebaum, Dr. Clair A. Henderson, Dr. A. D. Hess and Dr. S. W. Simmons.

* * *

Dr. L. G. Neal, Jr., Cleveland physician, recently reported for active duty with the U. S. Navy Medical Corps, Camp Lejeune, N. C. Dr. Neal served 30 months in the Army Specialized Training program during World War II and re-entered the service as lieutenant junior grade. Dr. Neal interned at City Hospital, Macon, and has been associated with his father, Dr. L. G. Neal, for the past two and one-half years.

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Dr. Harry B. Nunnally, Monroe physician, recently spent sometime in New Orleans taking postgraduate work at Tulane University of Louisiana School of Medicine. Dr. Nunnally was invited to speak on the subject, "Therapeutics as Applied to General Practice," by the dean of the medical college, Dr. M. E. Lapham, while in New Orleans.

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Dr. Sam E. Patton, Macon, president of the Bibb County Tuberculosis Association, was recently guest speaker at the Macon Optimist Club, and told them that 321 persons in Macon and more than half a million in the nation are suffering from tuberculosis. He showed a film entitled "Lease on Life" which emphasized the importance of regular physical check-ups.

* * *

Dr. Rufus F. Payne, Rome, director of Battey State Hospital, and a member of the special committee that is formulating detailed plans for the expansion of facilities at the Medical College of Georgia, Augusta, recently held an informal meeting with Dr. G. Lombard Kelly, president of the college, and college faculty. Details of the proposed expansion program were discussed. The purpose of the meeting, Dr. Kelly said, was to bring the faculty up to date on the planning that is going on. Dr. Kelly said that he feels very optimistic about the successful outcome of the planning, one feature of which is a proposal to erect in Augusta a \$12,000,000 state hospital, to be used as a teaching hospital for the Medical College of Georgia.

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Dr. W. A. Risteen, well known Augusta physician's work was featured recently in the *Saturday Evening Post* in an article entitled "They've Learned Something New About 'Strokes'". The article deals with results,

obtained in relieving paralysis through the use of "the stellate-ganglion block." It is, as the article points out, not a new treatment, having been first tried out 20 years ago by a French physician named Rene Leriche. Dr. Risteen began the use of the stellate-ganglion block in 1943 with marked effectiveness. Dr. Risteen, who is head of the neurology department of the Medical College of Georgia, together with Dr. Perry P. Volpito, head of the department of anesthesiology at the medical college, reported results on more than 250 cases where this method had been used in the treatment of paralysis.

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Dr. H. Wilder Smith, Swainsboro physician, who was called into active military service on August 14, 1950, when his National Guard Unit was activated, has been transferred from Camp Stewart to Camp Gordon.

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Dr. V. P. Sydenstricker, Augusta physician, recently returned from a tour of Scotland, England, Wales and Ireland, during which he had an opportunity to see the British socialized medical program in full swing. The whole set-up of the socialized medicine program in Great Britain seems calculated to corrupt the medical profession there, Dr. Sydenstricker reported to members of the medical staff of the University Hospital, Augusta. England, he said, is actively practicing socialism. It calls itself a welfare state. Practicality and common sense are conspicuously absent from the overall picture, he told Augusta physicians. The government has seized all of the government hospitals in England, Wales, Ireland, and Scotland, even the teaching hospitals, except, as to the last-named, in Scotland. Dr. Sydenstricker described Aneurin Bevin, the minister of health, as "the British Counterpart of John L. Lewis." All doctors are divided into two main classifications, he said, general practitioners and specialists. Within the specialist class there are junior specialists, senior specialists, super specialists, extra super specialists, and part-time specialists. Harley street specialists, private physicians in London who have always ranked in the top bracket of the profession, are not participating in the government program, Dr. Sydenstricker said. Salaries, fees, the number of patients, the number of home visits for the doctors in the general practitioner class are all fixed by the government. Ninety-five per cent of the hospital beds are free, but private rooms may be obtained upon payment of special fees, which are high, he said. It takes two years, however, to get a child's tonsils taken out, Dr. Sydenstricker said. The social welfare program in general was described as "fantastic" by Dr. Sydenstricker, who expressed a grave doubt as to Britain's ability to remain solvent under the financial drain this program is placing upon the government and the people.

* * *

The Sixth District Medical Society held its meeting at the State Health Department Building, Macon, December 7. Scientific program: "General Adaptation Syndrome", Dr. Leon Goodman, Macon; "X-Ray in Intestinal Obstruction in Infants", Dr. Herbert Olnick, Macon; "Bronchiectasis", Dr. T. P. Woodhall, Macon. Business session and election of officers. Banquet at Idle Hour Club. Dr. A. M. Phillips, Macon, secretary.

* * *

The Southern Medical Association will hold its forty-fifth annual meeting in Dallas, Texas, November 5-8, 1951. The following Georgia physicians are officers of the Southern Medical Association for 1950-1951: Section on Radiology: Dr. Robert C. Pendergrass, Americus, vice-chairman, and Dr. Stephen W. Brown, Augusta, secretary. Section on Urology: Dr. Harold P. McDonald, Atlanta, secretary. Section on Proctology: Dr. A. M. Phillips, Macon, vice-chairman. Section on Anes-

thesiology: Dr. David A. Davis, Augusta, chairman. Mr. C. P. Loran, Birmingham, Secretary, Treasurer and General Manager.

* * *

The Thomas County Medical Society met at the Nurses' Home of the Archbold Memorial Hospital, Thomasville, December 20. Scientific program: "Symptoms, Diagnosis and Treatment of Pelvic Endometriosis", Dr. Walter R. Holmes, Atlanta, professor of clinical gynecology, Emory University School of Medicine; "Present Status of Radioactive Isotopes", Dr. William Hamilton, Augusta, department of radiology, Medical College of Georgia; "The Significance of Gastrointestinal Bleeding", Dr. Lon W. Grove, Atlanta, associate professor of clinical surgery, Emory University School of Medicine. Following the scientific program dinner was served at the Glen Arven Country Club, Thomasville.

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The Fulton County Medical Society held its forty-sixth anniversary banquet at the Ansley Hotel, Atlanta, January 4. Call to order by Dr. A. O. Linch. Invocation; Installation of officers; "The Quest of First Principles in Higher Education", Dr. Kelley Barnett, Macon, Mercer University; "The Taxes Indeed Are Heavy", Dr. Hal M. Davison, Atlanta, president, Fulton County Medical Society; Announcement of committees; Presentation of the President's Key to Dr. A. O. Linch by Dr. Jack C. Norris, president-elect; Report of Committee on the Dr. L. C. Fischer Awards by Dr. Allen H. Bunce to Dr. Patrick C. Shea, Jr., award for the best original research paper in 1950, and the award for the best written scientific paper to Dr. A. Park McGinty. Presentation of Honorary President's Keys to Dr. Charles Giddings presented by Dr. Perrin Nicolson to Dr. Glenville Giddings, to Dr. L. C. Fischer presented by Dr. Edgar H. Greene, to Dr. F. Phinizy Calhoun, Sr., presented by Dr. James Edgar Paullin, and to Dr. Allen H. Bunce presented by Dr. W. A. Selman. Award of 25-Year membership certificates.

* * *

The Georgia Chapter of the American College of Surgeons and the Georgia Urological Association held a one-day joint session at the Hotel General Oglethorpe, Savannah, December 1. Officers of the Georgia Chapter of the American College of Surgeons are Dr. J. C. Patterson, Cuthbert, president; Dr. Peter B. Wright, Augusta, vice-president; Dr. David Henry Poer, Atlanta, secretary, and Dr. Joseph C. Read, Atlanta, treasurer. Dr. F. C. Holton, Savannah, and Dr. Hugh M. Lokey, Atlanta are councilors.

Officers of the Georgia Urological Association are Dr. Spencer A. Kirkland, Atlanta, president; Dr. W. R. Golsan, Macon, vice-president; and Dr. Reese C. Coleman, Atlanta, secretary-treasurer. Guest speakers on the joint program were Dr. F. E. B. Foley, St. Paul, Minn., professor of urology at University of Minnesota Medical School; Dr. Henry W. Cave, New York City, president of the American College of Surgeons, and clinical professor of surgery at Columbia University College of Physicians and Surgeons; Dr. Alfred Blalock, Baltimore, Md., Georgian famed for "blue baby" operations and now professor of surgery at Johns Hopkins University School of Medicine; Dr. Carl E. Badgley, Ann Arbor, Mich., professor of surgery, University of Michigan Medical School, and Dr. J. E. M. Thomson, Lincoln, Neb.

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Dr. George Arthur Geist, formerly of St. Paul, Minn., announces the opening of his office at 680 West Peachtree St., N. W., Atlanta. Practice limited to general surgery and surgical consultation. Dr. Geist is associated with Dr. D. L. Graydon, Atlanta.

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Members of the Medical Association of Georgia reported to Dr. Edgar D. Shanks, secretary-treasurer,

after the membership roster in the December, 1950 number of *The Journal* had gone to press: Georgia Medical Society, Chatham County: Dr. J. S. Howkins, 111 E. Gordon St., Savannah, Dr. A. J. Kelly, DeRenne Apts., Savannah, Dr. J. E. O'Neill, 202 E. Liberty St., Savannah, and Dr. A. J. Waring, Jr., DeRenne Apts., Savannah. Fulton County: Dr. C. E. Hall, Jr., 490 Peachtree St., N. E., Atlanta, and Dr. Carl A. Whitaker, Grady Memorial Hospital, Atlanta. Jenkins County: Dr. James C. Freeman, Sylvania. Laurens County: Dr. Wm. C. Thompson, Veterans Administration, Atlanta. Asso. Muscogee County: Dr. Clifford A. Peacock, 1327 Third Ave., Columbus, and Dr. J. T. Tidwell, Doctors Bldg., Columbus.

Dr. Cleveland Thompson, formerly of Millen, announces the removal of his office to 305 Sixth St., Waynesboro. Practice limited to general surgery.

CORRECTION: Listed in the December, 1950 number of *The Journal*, page 590, under Vice-Councillors for the Fifth District should be Dr. John W. Turner, Atlanta. Eighth District should be Dr. J. A. Leaphart, Jesup.

OBITUARY

Dr. Charles Mathew Bowcock, aged 92, former Atlanta physician died at his home, 831 Woodlawn Ave., Dallas, Texas, November 29, 1950. Dr. Bowcock, was a native of Clarksburg, W. Va., graduated from Jefferson Medical College of Philadelphia, Philadelphia, Pa., in 1892. He later did postgraduate work at Heidelberg, Germany, New York Postgraduate College and Columbia University, New York City. Dr. Bowcock practiced medicine for a while at Springfield, Ill., where he was active in civic and professional organizations. He served as president of the Illinois Medical Society and a chief medical physician at St. John's Hospital and Training School. Dr. Bowcock practiced in Atlanta from 1924 until 1944, when he retired and moved to Dallas. He was an associate member of the Fulton County Medical Society, the Medical Association of Georgia and the American Medical Association. He is survived by his wife; a son, Dr. Harold Mathew Bowcock, Kecoughtan, Va., and three grandsons, Harold Mathew Bowcock, Jr., Charles Robert Bowcock and James Zitzer Bowcock, all of Atlanta. Funeral services and burial were in Dallas, Texas.

Dr. Horace Darden, aged 92, retired Sparta physician, died in the Sandersville Hospital, Sandersville, November 16, 1950. Dr. Darden graduated from the University of Georgia Medical College, Augusta, in 1879, and was the oldest living graduate. He practiced medicine in Sparta until his retirement a short time ago. He was an honorary member and president of the Hancock County Medical Society, also a member of the Medical Association of Georgia and the American Medical Association. Survivors are one son, W. W. Darden, Union Point; a daughter, Mrs. Will Bell, Sandersville, and several grandchildren. Funeral services were held at the Sparta Funeral Home with the Rev. Roy Etheridge, of Royston, a former pastor, officiating. Burial was in the Sparta Cemetery.

Dr. John W. Ellis, aged 82, one of Cobb County's most beloved physicians, died at his Kennesaw home of a heart attack December 17, 1950. A native of Forsyth County, Dr. Ellis graduated from the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1900, and began the practice of medicine in Kennesaw, serving for more than a half-century, during which time he brought most of its population into the world. In addition to his medical practice, Dr. Ellis operated Kennesaw's only drug store, and carried on extensive farming operations. Until recent months, Dr. Ellis was available for anyone needing his services day or

night, and at the time of his death was still putting in a mansized working day. He spent over a quarter of a century making his calls on the sick via horse and buggy, until the automobile era took over. He was a member of the Cobb County Medical Society, the Medical Association of Georgia, and the American Medical Association. He was a stockholder in the old Marietta Hospital, and on the staff of the new Kennesaw Hospital, Marietta. Dr. Ellis married the former Carrie Boring, of Woodstock. She died in July 1944. Their children include Mrs. Clyde Ellison, Mrs. Charlie Guess, Mrs. Donna Jean Kemp, Mrs. Henry Hardy, and one son, Olin Ellis, all of Kennesaw. Another son, Henry Ellis, died in 1944, two months before his mother's death. Funeral services were held at the Kennesaw Methodist Church, of which he was a member, with the pastor, the Rev. R. R. Parker officiating, assisted by the Rev. J. M. Guest, Atlanta. Burial was in the City Cemetery, Kennesaw. Members of the Cobb County Medical Society formed an honorary escort.

Dr. William Robert Lowe, aged 65, Midville physician, died at his residence after an extended illness November 13, 1950. Born and reared in Warren County, the son of the late Rev. Charles and Annette Neal Lowe, he graduated from the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine, Atlanta, in 1909. He had lived and practiced medicine in Midville for the past 40 years. He was a member of the Burke County Medical Society, the Medical Association of Georgia, the Southern Medical Association, and the American Medical Association. He was past Council Commander of the W. O. W., for a number of years, and Worshipful Master several times of the Midville Masonic Lodge 512. In 1949 he was District Grand Master of Masonic bodies in the First District, and members of Alee Temple Shriners; County Commissioner of Burke County for a number of years, and a member of the school board of Burke County for many years. He is survived by his wife, the former Miss Mary Veazey of McRae; two daughters, Mrs. D. H. Brown, Moultrie; Mrs. C. A. Adamson, LaGrange; one son, W. R. Lowe, Jr., Savannah, and a brother C. C. Lowe, Atlanta. Funeral services were held at the Midville Methodist Church with the Rev. David Lastinger and the Rev. Joe Branch officiating. Honorary escort were members of the Burke, Screven and Jenkins Counties Medical Societies, and Midville Masonic Lodge 521. Burial was in the Midville Cemetery.

Dr. John Saliba, aged 81, widely known retired Savannah physician, died at his home, 718 Washington Avenue, Savannah, November 16, 1950. A native of Lebanon, Syria, he graduated from the University of Edinburgh Faculty of Medicine, Edinburgh, Scotland, in 1893. He continued his studies for two years at the universities of Paris and Vienna, and later attended the medical college at Constantinople, where he received another doctor of medicine degree. He served as chief surgeon at St. George's Hospital in Beirut, and attended clinics at Edinburgh, and was appointed civil surgeon to the British Armed Forces, then fighting the Boers in South Africa. He moved to London, England, in 1905, where he became director of the newly formed Eastern Transvaal Plantations, Ltd. At the same time he established private practice in Durhamshire and later in Northumberlandshire. America attracted him during a visit in 1906, and he moved here in 1913. He established the Albemarle Hospital at Elizabeth City, N. C., where his patients included many naval and marine patients. In 1930 he moved to Savannah because of illness. He was before his retirement a member of the North Carolina State Medical Association and the American Medical Association. Survivors include four sisters, including Mrs. Regina Thomas, Savannah, with whom he made his

home, a brother and a number of nieces and nephews. Funeral services were held at Christ Episcopal Church, of which he was a communicant, with the Rev. F. Bland Tucker, D.D., rector officiating. Burial was in Bonaventure Cemetery, Savannah.

NEW BOOKS

Bronchoesophagology by Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., Honorary Professor of Bronchoesophagology and Laryngeal Surgery, Temple University, Philadelphia; and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S., Professor of Bronchoesophagology and Laryngeal Surgery, Temple University, Philadelphia. 366 pages, 7x10 inches, with 260 illustrations. Philadelphia and London, W. B. Saunders Company. Price: \$12.50.

This book contains much material on the endoscopic removal of foreign bodies, but its usefulness extends far beyond that area. Very valuable to the surgeon, for instance, are its clear descriptions of how to use the bronchoscope and esophagoscope in: visual inspection of lesions in situ; procurement of specimens for biopsy; and localization of foreign bodies for surgical removal. A detailed explanation is presented of the swab method of obtaining cytologic specimens in suspected carcinoma of the lung. Use of this method often permits definitive diagnosis a considerable time before exfoliative material appears in the sputum. Emphasized throughout are "dangers and pitfalls to be avoided."

* * *

Binocular Vision by Kenneth N. Ogle, Ph.D., Section on Biophysics and Biophysical Research; Research Consultant in the Section on Ophthalmology, Mayo Foundation and Mayo Clinic. 345 pages, 6½x9½ inches, with 182 illustrations. Philadelphia and London, W. B. Saunders Company. Price: \$7.50.

This is the first book on the subject in the English language. It is actually an analysis—based on years of research by Dr. Ogle and a number of colleagues at the Dartmouth Eye Institute—of the anatomic, physiologic, and psychologic aspects of binocular vision, including both the normal and the various deviations from normal. The volume considers the structure and functions of the visual apparatus and correlates this information with the psychology of vision. Finally, Dr. Ogle discusses ways and means of correcting deviations from the normal, and describes the equipment and mathematical formulae available for testing adaptation of the eyes, individually or together. Recommended for ophthalmologists, physiologists, and students in various fields.

* * *

Regional Orthopedic Surgery by Paul C. Colonna, M.D., Professor of Orthopedic Surgery, University of Pennsylvania Medical School. 706 pages, 6½x9½ inches, with 630 illustrations on 474 figures. Philadelphia and London, W. B. Saunders Company. Price: \$11.50.

This book will make for surer diagnosis, more effective treatment of diseases and anomalies of the bones and joints; and will be an aid in the management of traumas. Dr. Colonna first reviews the anatomy of each region giving you a graphic illustration of the normal joint function and showing the arc of movement. Then he takes up the diseases of the region, with consideration of pathology, diagnosis, treatment and prognosis. Injuries to the bones and joints of each region are covered thoroughly. Advice is given on simple office orthopedics such as flat feet, ingrown toenails, bursitis, etc. Recommended as a working guide for orthopedic surgeons and as a reference for general practitioners, surgical residents, and other interested physicians.

* * *

Natural Childbirth by Frederick W. Goodrich, Jr., M.D., 176 pages, 5½x8¼ inches, illustrated. New York, Prentice-Hall, Inc., 1950. Price: \$2.95.

This manual for expectant parents has an authoritative answer for every question that arises from the first days of pregnancy on through the problems of post-natal care. It is complete with diets and exercises; and is crammed with helpful diagrams and illustrations. Dr. Goodrich addresses his reader as he would a patient in his office. The emphasis throughout is on the naturalness of the birth process, the need of knowledge to dispel fear and the complete cooperation which can exist between a woman and her doctor. Obstetricians can wholeheartedly recommend this book to their patients as a helpful and complete course on childbirth. It will complement and enhance the efforts of a woman and her doctor to establish a firm basis of mutual trust and understanding.

* * *

Physiology of the Eye by Francis Heed Adler, M.A., M.D., F.A.C.S., William F. Norris and George E. de Schweinitz, Professor of Ophthalmology, School of Medicine, University of Pennsylvania, and Consulting Surgeon, Wills Hospital, Philadelphia. 710 pages, 7x10 inches, with 319 illustrations. St. Louis, The C. V. Mosby Company, 1950. Price: \$12.00.

Dr. Adler states in the preface that "the application of physiology to the study of disease has been richly rewarded in many fields of medicine and surgery. The time has come when knowledge of the function of the various parts of the eye can be likewise applied to ocular disorders. The ophthalmologist should know how the various portions of the eye normally function before he can adequately treat their diseases. A book is needed, therefore, which offers to the student and the practicing ophthalmologist the recent findings of the physiology of the eye gleaned from the experimental laboratory, and which applies these facts clinically." The volume, which is ably illustrated by the drawings of Miss Marie Wilson, is concerned mainly with the clinical application of the physiology of the eye. We believe that the author has accomplished his goal as stated in the above excerpt from the preface.

ANOTHER STUDY SHOWS ANTIHISTAMINICS INEFFECTIVE IN TREATMENT OF COLDS

Carefully controlled studies conducted at the University of Illinois College of Medicine and the Chicago College of Optometry "demonstrate that antihistaminic drugs do not prevent, abort, shorten, curtail, reduce or stop the common cold," according to Dr. Noah D. Fabricant of Chicago.

Dr. Fabricant, clinical assistant professor of otolaryngology at the university, reported these findings in the *A.M.A. Archives of Otolaryngology*, published by the American Medical Association. He confirmed numerous similar studies in the United States and Great Britain.

"It was observed," he said, "that antihistaminic drugs are no more effective than placebos in aborting a cold and that there is no validity to the contention that antihistaminic drugs are more effective if taken within a short time after the start of a cold."

He cited like findings in other studies and added that "sufficient time has elapsed and enough convincing evidence has been accumulated" to establish the ineffectiveness of the drugs in the treatment and prevention of colds.

Dr. Fabricant's studies involved 139 students at the Chicago College of Optometry and 74 students at the University of Illinois College of Medicine. They were conducted through the winter and early spring of 1950.

FOR SALE—100 Ma Continental 1948 model x-ray with tilt table and fluoroscope. For sale due to the departure of former associate. Contact Dr. M. B. Bowman, 403 Broad Avenue, Albany, Ga.

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THE TREATMENT OF INTRACTABLE DYSMENORRHEA BY PRESACRAL SYMPATHECTOMY

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and

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Atlanta

Twenty-five years have passed since Cotte described resection of the superior hypogastric plexus, or presacral nerve of Latarjet, as a surgical treatment of dysmenorrhea. Despite his claims which have been substantiated by many others and by large series of cases, those who are interested in the subject are impressed by the lack of acceptance by many physicians of the value to be obtained from this procedure. It is the purpose of this paper to re-emphasize the gratifying results obtainable and to report a small series of cases from our private practice. No apologies are offered for the small number of cases, since these cases were highly restricted and had absolute indication for the operation.

It is estimated that one out of every three or four normal women will have menstrual pain varying from mild discomfort to severe incapacitating pain which requires bed rest, sedatives, analgesics and even opiates. Severe pain each month is an ordeal which is dreaded and feared and may cost the working woman several working days with each episode. The treatment of dysmenorrhea should first be on a conservative basis with the use of antispasmodics, hormones, psy-

chotherapy, childbearing and D&C. The use of the stem pessary in use 25 years ago has fortunately been almost entirely abandoned because, although it relieved pain in some cases, it was frequently followed by pelvic infection and sterility. Conservative treatment, however, frequently is not very satisfactory and it is in the intractable group that presacral sympathectomy should be offered. Duncan states that any girl totally incapacitated for 24 hours or longer when the difficulty has continued for a year or more should be given the benefits of a presacral neurectomy. An exception to this is the highly strung, nervous, unstable and neurotic type where any type of surgical procedure would be contraindicated. A test we have used with some success is to ask the patient if she is willing to undergo an abdominal operation with an 80 to 90 per cent chance of relief of her pain. Many borderline cases will be eliminated by this method but we have found those women with incapacitating and severe pain to accept surgery readily.

Dysmenorrhea may be divided into two major types: primary, which is unassociated with pelvic disease; and secondary, in which there is other pelvic disturbance such as malpositions, endometriosis, tumors, etc. Primary dysmenorrhea is usually more severe and occurs more frequently before 20 years of age. It is characterized by severe "cramps" which are due to contraction of uterine muscle fibers. In this group presacral sympathectomy will give relief in 90 to 98 per cent of cases.

The results in the treatment of secondary

dysmenorrhea are excellent but less spectacular than with the primary type, with about 80 per cent relief of symptoms. It has also been noted in secondary dysmenorrhea that correction of coexisting pelvic pathologic changes at the same time gives a higher percentage of relief than when presacral sympathectomy alone is done. Meigs in 1939 reported a series of cases of secondary dysmenorrhea treated by presacral sympathectomy alone but only 75 per cent had complete relief of their symptoms. In another series in which pelvic disease was also corrected at the same time good results were obtained in 85.7 per cent.

Although the theory that dysmenorrhea was due to displacements of the uterus has been disproved, it is still common to see patients who have had a D&C, suspension and appendectomy who still have severe menstrual pain. Therefore, we feel that these patients should also be given the benefit of a presacral resection, at the time of first surgical commitment. The conservative surgical treatment of endometriosis should follow a similar pattern. Presacral sympathectomy is a valuable adjunct in affording relief to these women at menstrual time when complete ablation of the pelvic organs is not indicated. It must be said, however, that pain of ovarian origin, or discomfort arising in the perineum, labia or external genitalia will not be relieved by presacral resection as these structures are not supplied by the hypogastric nerves but have a different innervation.

Fontaine and Hermann report that division of the presacral nerve does not appreciably alter normal physiology of the pelvic organs. They found that there was no interference with the normal menstrual cycle or with labor in pregnancy; also there was no glandular atrophy, chronic pelvic congestion, or any disturbance in motor function of bladder or rectum and no change in

libido. Some workers have reported a less painful and shorter first stage of labor.

The superior hypogastric plexus (Fig. 1) is the chief sensory pathway from the bladder, rectum and the internal genitalia with the exception of the ovary and part of the fallopian tube. It is formed at the bifurcation of the aorta by a junction of the intermesenteric nerves. These in turn are derived from the solar plexus and pass downward anterior to the aorta receiving fibers from the inferior mesenteric and lumbar ganglia in their descent. It is a moderately wide plexus and in about 20 per cent of cases is a single fused nerve. Just below the level of the promontory of the sacrum it forms the middle hypogastric plexus which bifurcates to form the bilateral hypogastric plexus or hypogastric nerves. Each consists of two or three interlacing nerves forming a long narrow plexus which pass downward and lateralward into the broad ligament at the level of the third sacral vertebra. It thus surrounds the rectum in the form of a horseshoe as it passes to join the pelvic plexus.

Technic

We routinely use spinal anesthesia as it offers perfect relaxation. A D&C is always done. The patient is placed in a moderate Trendelenberg position and a vertical incision from the umbilicus to the symphysis, or Pfannenstiel type incision is made. The classic Pfannenstiel occasionally will cause some technical difficulty in carrying the dissection of the plexus high enough. The sigmoid is retracted laterally and the small bowel packed superiorly, thus exposing the posterior parietal peritoneum. This is grasped over the promontory of the sacrum and two guide sutures of 000 black silk are inserted. The peritoneum is then opened in the midline in a vertical fashion between the two sutures. There immediately appears a loose arrangement of cobwebby connective tissue through which runs the nerve plexus. This tissue is brushed off of each flap of peritoneum, the nerve is picked up as the plexus passes through the triangle formed by the promontory of the sacrum below, the bifurcation of the aorta above and the common iliac arteries on each side. As soon as the nerve fibers are definitely identified by their formation into a resistant trunk, which runs superiorly and inferiorly, a tape is passed under the nerve for traction. With this in place a Kuttner dissector or gauze sponge is then employed to thoroughly dissect all fibers. Thoroughness and meticulousness is as important here as with any other sympathectomy as an incomplete operation will leave intact fibers to further transmit painful impulses. Gentleness will assure a bloodless field which will aid materially. Frequently overlooked fibers run under the common iliac vein, rather than anterior to the vein from the 4th lumbar ganglia. Care must be taken not to injure the left common iliac vein, the common iliac arteries, the

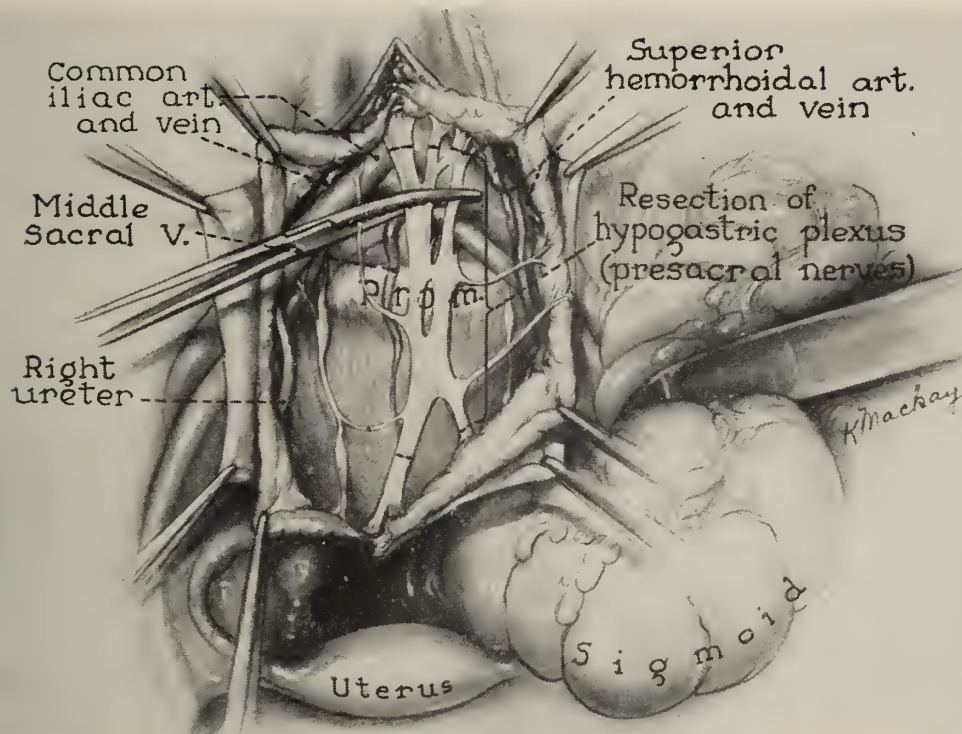


Fig. 1. Superior hypogastric plexus.

ureters and the superior hemorrhoidal and sigmoidal vessels in the mesosigmoid. The left ureter is rarely seen unless exposed lateral to the superior hemorrhoidal vessels but it is important to remove all the nerve fibers between the two ureters. The middle sacral vessels can be preserved with gentle dissection as they are closely attached to the bony structures but if damaged can be ligated with no ill effect. After the plexus is completely isolated the superior portion is clamped, cut and ligated 2 to 3 cm. above the bifurcation of the aorta. The trunk is then dissected further inferiorly until it is divided into the two hypogastric nerves, which is usually at the level of bifurcation of the common iliac arteries. Each of these nerves is then carefully isolated down to the point on each side where it enters the broad ligament to join the pelvic plexus. If the dissection is carried below this point and the parasympathetic components are injured, it is quite possible that urinary incontinence might result. The hypogastric nerves are then ligated, cut and severed and the excised nerve trunk saved for pathologic examination. This amount of resection almost precludes nerve regeneration. Upon completion of the excision the above mentioned triangle should be bare exposing the periosteum of the promontory and 5th lumbar vertebra with the middle sacral vessels anteriorly. The peritoneum is then closed with sutures of 000 silk.

In our series 18 cases have been operated upon, 10 being cases of primary dysmenorrhea and eight of secondary dysmenorrhea. Of these, 14 (77 per cent) were completely relieved and 4 improved. There were no cases without improvement. Of the 10 with primary dysmenorrhea, 8 (80 per cent) were completely relieved and 2 were improved; of the secondary cases, 7 (82

per cent) were cured and 1 improved.

Ten of the 18 cases had had previous appendectomy, two cases had had stem pesaries and D&C, three cases had had suspensions and one case had had a right ovarian cyst removed.

The oldest patient was 30 years of age, the youngest 18 and the average age was 24. Thirteen of the women were married and five were single. Six had had children, two of the primary type and four of the secondary type, which suggests that marriage and childbearing cannot be depended upon to relieve severe dysmenorrhea.

Eight of the 18 operations were supplemented by shortening of the uterine ligaments and five cases were supplemented by appendectomy. There were no postoperative complications in this series.

Summary

1. Gratifying results may be obtained in treatment of intractable dysmenorrhea by presacral sympathectomy.

2. Conservative treatment is advocated prior to surgery.
3. Best results are obtained in cases of primary dysmenorrhea, but the procedure is a valuable adjunct in treatment of severe secondary dysmenorrhea.
4. The anatomy and technic of resection of the superior hypogastric plexus are discussed.
5. A series of 18 cases are reported with complete relief in 14 and improvement in 4. There were no cases in which there was no improvement.

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The Medical Association of Georgia will hold its 1951 annual session in Augusta. The dates are April 17, 18, 19 and 20. Bon Air Hotel will be headquarters, with Partridge Inn participating. Please make your reservations now.

THE DIAGNOSIS AND PREOPERATIVE MANAGEMENT OF CONGENITAL ESOPHAGEAL ATRESIA AND TRACHEO-ESOPHAGEAL FISTULA

OSLER A. ABBOTT, M.D.

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Congenital abnormalities of the esophagus were formerly considered to be of rare occurrence. However, in 1947 Lyon and Johnson¹ were able to find reports of approximately 468 cases of esophageal atresia with or without tracheo-esophageal fistula. Interest in this lesion has been stimulated during the past decade during which successful operative maneuvers have been developed which may be expected to salvage 70 per cent of these infants. The lesion was described by Durston² in 1670 and Gibson³ in 1703 and by Martin⁴ in 1821. This lesion previously considered a rarity was recently estimated by Sir G. Gray Turner⁵ to occur almost as frequently as harelip and cleft palate. In 1947 Ladd and Swenson⁶ stated, "It is undoubtedly true that many infants still die of esophageal atresia without its having been diagnosed." In 1949 Bigger⁷ presented a very complete history of the therapeutic aspect of this disease. A London surgeon, Mr. T. Holmes⁸ in 1869 was understandably pessimistic but did suggest the possibility of end-to-end suture of the esophageal segments. In the early part of this century the therapeutic approach was confined to the use of gastrostomy alone which was uniformly futile. In 1904 Villemain⁹ passed a gastrostomy tube into the first portion of the jejunum hoping to decrease the degree of regurgitation of food and its aspiration through the fistula. No benefit

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Read before the Medical Association of Georgia in annual session, Macon, April 20, 1950.

was obtained from this maneuver. The first surgeon to appreciate the major importance of primary closure of the tracheo-esophageal fistula was apparently Richter¹⁰ of Chicago. He carried out this procedure through a posterior mediastinal approach in two infants, but in both instances the patients died. The first end-to-end suture of the esophageal segments was carried out by Lanman¹¹ of Boston in 1936. The first successful direct anastomosis was reported in 1943 by Cameron Haight¹² of Ann Arbor. Success by means of multiple stage procedures utilizing closure of the fistula, gastrostomy, and cervical implantation of the proximal esophageal segment was first reported in 1939 by Leven¹³ of St. Paul, and Ladd¹⁴ of Boston. Following the cardinal success of Haight in 1943 numerous reports of successful primary end-to-end anastomoses have appeared. It is now estimated that a primary end-to-end anastomosis can be achieved in approximately 85 per cent of the patients, while the remaining 15 per cent will need to utilize the indirect or multiple stage procedures, and then achieve esophago-gastric continuity at a later date through various types of surgical procedures such as those which have been utilized by Sweet¹⁵, Rienhoff¹⁶, and Potts¹⁷. With early diagnosis of the lesion, satisfactory pre-operative management, and appropriate surgical attention, these infants should now be allowed to survive in approximately 70 per cent of instances. The mortality rate of 30 per cent will in all probability be decreased as time progresses, but the frequency of associated serious anomalies can be expected to prevent the achievement of a mortality rate much below 10 to 15 per cent.

Embryology

The embryologic aspect of these types of congenital esophageal defects has been very succinctly described by Ladd and Swenson⁶.

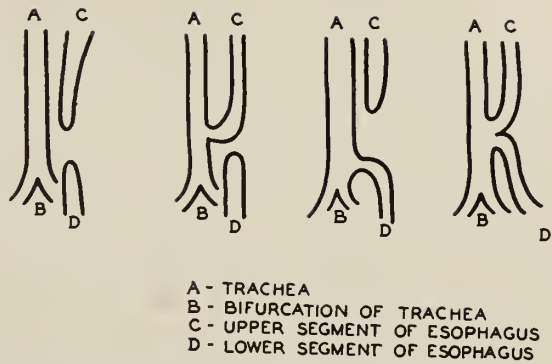


FIG. 1.—Congenital atresia of the esophagus. Illustrating the relationships which may exist between the esophageal segments and the trachea. In addition, complete agenesis of the esophagus may occur and, rarely, tracheo-esophageal fistula in the absence of esophageal atresia.

They remind us that in early fetal life the trachea and esophagus constitute a single tube. This tube undergoes division of an ingrowth of mesoderm early in fetal life. Concomitant with this mesodermal ingrowth, the esophageal lumen undergoes obliteration by means of a rapid proliferation and concrescence of its epithelial lining. Subsequent vacuolization of this solid cord occurs; and with coalescence of these vacuoles, re-establishment of the lumen is obtained much in the same manner as that which occurs in the intestine. Thus, it is seen that if there is developmental arrest or incomplete separation of the trachea from the esophagus that a tracheo-esophageal fistula will occur. Similarly, if the process of vacuolization to form an esophageal lumen is arrested, then atresia of the esophagus results.

Pathology

There are considerable variations which may be found in regard to this group of congenital anomalies. In 1929 Vogt¹⁸ drew attention to the three main types of congenital atresia of the esophagus. These are demonstrated in a reproduction of his original diagram in Figure 1. He designated the types as follows:

- I. Agenesis of the esophagus.
- II. Atresia of the esophagus; no communication with the trachea.
- III. Atresia of the esophagus; fistulous

communication with the trachea or (rarely) with one of the main bronchi.

- (a) Fistula between the proximal segment of the esophagus and the trachea. Proximal end of the distal segment ends blindly at about the level of the bifurcation of the trachea.
- (b) Proximal segment ends in blind pouch; distal segment communicates with the trachea or rarely with one of the main bronchi.
- (c) Both proximal and distal esophageal segments communicate with the trachea.

A further modification of this latter anomaly is the so-called H-type of fistula such as occurs in the absence of esophageal atresia.

The occurrence of a tracheo-esophageal fistula in the absence of esophageal atresia had been considered an extreme rarity. In 1948 Haight¹⁹ described the first incidence of this type of lesion being diagnosed during life and undergoing successful corrective surgery. It has been the experience of the authors to encounter three such patients within the past two years, and they are being presented elsewhere²⁰. It is felt that this lesion should be emphasized inasmuch as the symptomatology presented by such a lesion may differ considerably from that seen when the tracheo-esophageal fistula occurs coincident with esophageal atresia. In the absence of esophageal atresia, a soft catheter can be passed easily down the esophagus into the stomach. Also in such lesions the infant may have episodes of taking small feedings without difficulty. These children have less tendency to salivate excessively, and the main factor drawing attention to this type of abnormality is that difficulty may only be encountered with feedings of more than one ounce in amount, and the episodes of cyanosis may occur as

long as 30 to 60 minutes following the feeding. Also, these children may show a distinct variance in respiratory difficulty subsequent to feedings according to the position in which the child is fed or in which the child is kept following the feeding. Frequently, the only symptoms or signs may be those of pulmonary contamination. It is felt that this lesion is probably of much greater frequency than previously considered.

In discussing the pathology of this subject, one must remember the frequency with which multiple anomalies may be presented by the same infant. Ladd and Swenson⁶ described 91 malformations occurring in 114 patients noted to have esophageal atresia and tracheo-esophageal fistula. However, these authors go on to state, "In some instances more than one anomaly occurred in one patient, and many were not of a serious nature." They estimated that 18 of these malformations either made it necessary to modify the treatment or caused the death of the baby. The serious anomalies noted in their last 82 cases consisted of five instances of atresia or stenosis of the intestine, five patients with associated imperforate anus, and thirteen patients with congenital heart disease, while two had serious anomalies of the urinary tract. It should be noted that in 94 infants with esophageal atresia Plass²¹ found evidence of 59 associated anomalies; in 24 of these there was atresia of the anus.

Symptomatology

The possibility of congenital abnormality of the esophagus must be considered in any infant who presents excessive salivation or frothy mucus in the mouth during the first 24 hours of life. This excessive salivation will persist until the esophageal obstruction is overcome. In reviewing our own cases, we have been impressed with the frequency with which these children are noted to be difficult to resuscitate at the time of birth. We feel, therefore, that a child who has

cyanosis at birth and difficulty in resuscitation should be considered suspect of this lesion. This is particularly true in the child in whom difficulty in resuscitation or persistent cyanosis is noted for the first hour or more subsequent to delivery. In any child having esophageal obstruction such as is presented by atresia of the upper segment, the infant will vomit all fluid offered. A child having a fistulous communication between the upper segment and the tracheo-bronchial tree will present cyanosis upon feeding. Any infant vomiting his first feeding must be suspected of having this abnormality, and any infant who vomits and becomes cyanotic upon his first feeding must be considered to have the abnormality until proven otherwise.

The symptomatology produced by this lesion does vary according to the age of the child. If the lesion is suspected in the first two to three days of life, the predominant symptomatology is that of difficulty in feeding and episodes of cyanosis and excessive salivation. As time progresses, the pulmonary contamination, both due to the fistula and overflow regurgitation from the upper esophageal pouch down into the trachea or from an upper esophageal tracheo-esophageal fistula, makes the pulmonary pathology the outstanding symptom. Pneumonia, therefore, as well as areas of atelectasis become an outstanding finding usually from the fourth day onward. However, it is seldom that the lungs of these children sound completely dry even in the first, second, and third days of life. Therefore, a child with rales or an x-ray showing areas of atelectasis must be suspected of harboring an esophageal anomaly. Just as one must suspect the possibility of other abnormalities when one discovers a tracheo-esophageal fistula with esophageal atresia, so also must one be suspicious of and look for the possibility of tracheo-esophageal pathologic changes when

presented with other anomalies discovered upon the immediate post-natal examination.

It would be well to consider briefly the differential diagnoses to be considered in the newborn child which can, to some extent, imitate tracheo-esophageal fistula. Of course, the immediate difficulty in resuscitation during the first few hours of life can be produced by other lesions than tracheo-esophageal abnormality. Such can be seen in the heavily sedated infant. Primary atelectasis may produce this syndrome. Aspiration of meconium or amniotic fluid may produce early signs of pulmonary disease. Atelectasis, particularly of the right upper lobe with or without associated swallowing difficulty may be seen in infants harboring anomalies of the aortic arch such as the vascular ring.

In summary then, the significant symptomatology presented by tracheo-esophageal anomalies consists of: (1) Difficulty in resuscitation at birth with cyanosis persisting beyond the first hour occurs in many cases. (2) Excessive salivation. (3) Difficulty associated with the first attempt at feeding noted either as immediate vomiting or associated cyanosis. (4) The frequent presence of other congenital abnormalities. (5) Secondary pulmonary complications such as atelectasis and pneumonia which appear with increasing frequency with increase in age of the infant. (6) Dehydration may be a prominent finding in a child over five days of age. (7) Abdominal distention is usually a notable factor in infants wherein the lower esophageal segment communicates with the trachea. (8) Infants presenting an H-type fistula without atresia may present a different type of syndrome.

Diagnostic regimen

Certainly the most important factor in the diagnostic regimen involved in these infants is a strong consciousness of the possibility of

occurrence of tracheo-esophageal anomalies. Physical findings revealed by these children consist mainly of some excess in salivation and, according to the age of the child, the findings of atelectasis or pneumonia may be present. One is impressed in reviewing a series of these patients with the degree of abdominal distention which is usually presented by the children having tracheo-esophageal fistula communicating with the lower esophageal segment. It is rare that these children do not have distinct abdominal distention and a pronounced air filling of the gastrointestinal tract on x-ray examination. This must be kept in mind in the patients having both tracheo-esophageal fistula and imperforate anus. They are frequent concomitant anomalies, and both are prone to produce abdominal distention. In infants having both a fistulous communication to the lower esophageal segment and an atresia lower in the gastrointestinal tract, particularly such as may be seen in atresia of the second portion of the duodenum, the degree of gastric distention may be very striking. It has been our experience and the experience of others, that when these anomalies are concomitant one can hear with the stethoscope an inrush of air into the stomach with each respiratory effort. When one is presented with salivation, cyanosis on feeding, abdominal distention and varying degrees of signs of pulmonary disease, certainly the next step in the diagnostic investigation is a P.A. x-ray such as to include both the thorax and the abdominal cavity. This plain x-ray may reveal varying degrees of atelectasis and/or pneumonia. The gastrointestinal air pattern will vary with the type of abnormality seen in the esophagus. If one is presented with the more common type, that of the blind upper esophageal segment and the lower segment communicating with the trachea, or, as is rarely seen, with one of the bronchi, then there will be a

marked distention of the stomach and bowel with air.

Cameron Haight has noted that in rare instances, when presented with a small fistulous communication, air may be small in amount or even absent from the gastrointestinal tract. If one is confronted with the type of abnormality in which the upper esophageal segment communicates with the trachea and the lower esophageal segment is either atretic or absent, then the complete absence of air from the gastrointestinal tract is seen. This is a very significant finding, and any newborn infant showing no gastrointestinal air pattern must have an obliterative lesion obstructing the passage of air from the oral cavity into the gastrointestinal tract. On rare occasions it has been our experience to note suggestive evidence of an enlarged lower esophageal segment communicating with the trachea on lateral x-ray views. This may be brought out more distinctly by having the infant in the upright position and utilizing some abdominal compression at the time of taking the lateral x-ray film.

There are certain very important factors to be considered in utilizing contrast media in the further study of these infants. The extreme danger of the ingestion of barium has been strongly emphasized by all authors dealing with this subject. The ingestion of barium can, of course, produce tragic results in the patient having a tracheo-esophageal communicating with the upper esophageal stump. The direct passage of barium into the the tracheo-bronchial tree produces considerable plugging of the smaller bronchi and bronchioles. This complication is equally serious when barium ingestion is utilized in the patient having a blind upper esophageal pouch. The newborn infant aspirates easily. Even small amounts of any type of contrast media placed in the upper pouch may be regurgitated and go down the

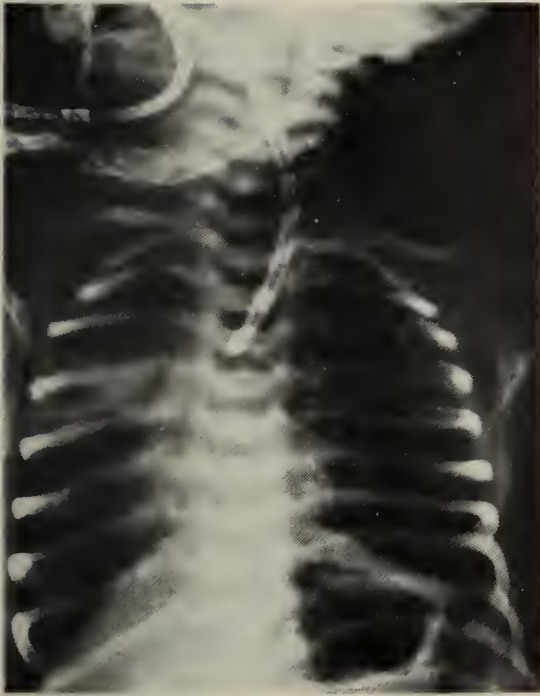


Fig. 2. X-ray film taken during fluoroscopic study with passage of a No. 14F catheter. Catheter meets a complete obstruction at the lower end of the blind upper esophageal pouch at level of 3rd dorsal vertebra. This finding plus the x-ray evidence of air in gastrointestinal tract predicts an upper blind pouch while the fistula will be between the trachea and the lower esophageal segment.

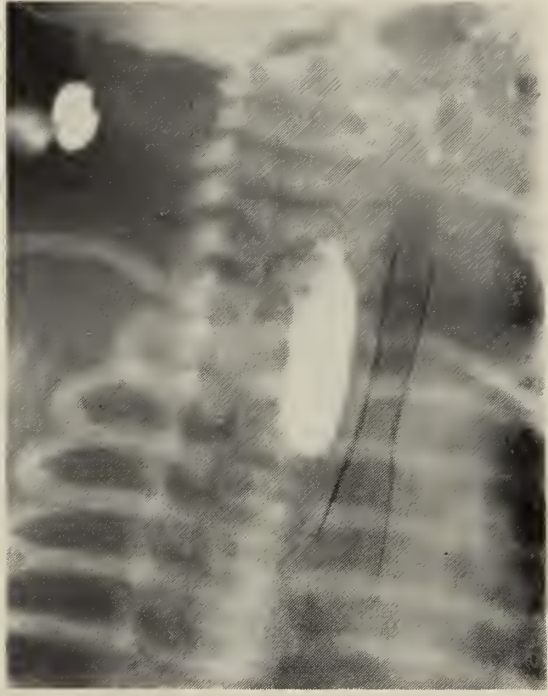


Fig. 3. Spot x-ray film taken following injection of lipiodol into blind upper esophageal pouch. This would only be done after this pouch has been thoroughly cleansed. Lipiodol is the only contrast media recommended and this should be instilled through a catheter in small amounts (1 cc.).

trachea. We have been particularly impressed with the character of the secretions found in a blind upper esophageal pouch. As the baby grows older the contents of this upper pouch become increasingly foul, due to stasis, and show a marked tendency to form particles of coagulum. It is therefore vitally important that no contrast media of any type be utilized in the study of these patients until the upper esophageal pouch has been thoroughly aspirated and cleaned.

The only safe contrast medium which may be used to study the upper esophageal pouch consists of a small number 10F or 12F soft rubber catheter. This must be passed under fluoroscopic vision. In one of our patients, tracheo-esophageal disease was suspected within the first forty-eight hours of life. A soft rubber catheter was passed in the nursery and seemed to pass easily. It was not until the fourth day of life following persistence of symptoms that a

soft catheter was passed under fluoroscopic guidance and was found to curl up in markedly dilated upper stump. The catheter tends to meet a characteristic obstruction at about the level of the second dorsal vertebra and then will tend to bend back on itself (see Figs. 2 and 3). If one is not satisfied with the information obtained in this manner, then following satisfactory aspiration and cleansing of the upper esophageal pouch, 0.5 to 1.0 cc. of lipiodol may be introduced into the base of the pouch through the indwelling catheter. The size and mobility of the upper pouch may be best studied under the fluoroscope, as misleading information may be obtained if purely roentgenograms are utilized. This has been emphasized by Haight.

One further matter needs mentioning relative to the utilization of lipiodol. In the rare instance of the H-type of fistula, the tracheo-esophageal fistula without associated atresia, the catheter may pass easily

down into the stomach. If, however, one suspects the presence of an H-type of fistula, then the catheter should be withdrawn to the level of the first dorsal vertebra and 0.5 to 1.0 cc. of lipiodol injected. In some instances, the fistula may only be demonstrated if this study be carried out with the patient in the face-down position. In other instances it is necessary to pass the catheter down to the level of the fifth dorsal vertebra and with the patient in a slight Trendelenburg position, face-down, then the contrast media is injected. In our series of three patients with this type of abnormality, the fistula has in each instance presented much higher in the trachea than that which is seen with other types of abnormality. Furthermore, the fistulous tracts in all three have entered the trachea at a much higher level than the point of entry of the fistula into the esophagus so that the tract runs from the esophagus to the trachea in a cranial direction (see Fig. 4).

In some instances it may be necessary to utilize endoscopic measures in order to prove or to rule out the possibility of tracheo-esophageal fistula. When we are confronted with this problem, it is our plan to do a primary esophagoscopy. If one encounters a narrowed area of the esophagus, or possibly visualizes the esophageal fistula from this angle then one has not subjected the child to the risk of subglottic edema which may occur from bronchoscopy. Under any circumstances the esophagus is thoroughly cleansed out by means of the esophagoscope prior to bronchoscopy in all such infants. If bronchoscopy must be resorted to it may be carried out with a fair degree of safety and a fistula, if present, will usually be seen to arise from the posterior wall of the trachea at any point from a distance 3 cm. above the carina down into the upper portion of one of the mainstem bronchi most commonly in the left.



Fig. 4. Spot x-ray film taken during special study recommended for H-type esophago-tracheal fistula without esophageal atresia or stenosis. Note outlining of fistula with lipiodol at a higher level than fistula presents in the more common types.

Preoperative management

The preoperative management and preparation of these children is at least of equal importance to the dexterity of the operating surgeon. The basic principle in the preoperative management of these infants is to utilize all measures possible to prevent pulmonary contamination. Certainly, therefore, in any child in whom there is true suspicion of the possibility of this diagnosis, nothing must be given by mouth. The upper esophageal stump must be kept dry of secretions to

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prevent overflow aspiration. This may best be accomplished by placing a small nasal catheter into the upper esophagus and keeping a slight negative pressure on this. Such a catheter will frequently become occluded with the inspissated mucus and may need very gentle irrigation with small amounts of saline. The more common method of aspiration of the pharynx, consisting of frequent use of oropharyngeal suction with a bulb syringe is to be condemned as it has been our experience that this may frequently produce considerable edema and trauma of the soft palate. Repeated passage of a nasal catheter may produce bleeding and blood aspiration. Once the upper esophageal stump is aspirated and kept dry, then the preferable position is that of reverse Trendelenburg in order to decrease the chances of contamination of the tracheo-bronchial tree by the gastric secretions, if one is presented with a fistulous communication to the trachea through the lower esophageal segment.

An extremely valuable measure in the preoperative management of these patients has been stressed by Cameron Haight and further emphasized by Bigger. One must expect a certain period of decreased pulmonary function on the side utilized for operation. Either side may be utilized, although the right extra-pleural approach is preferred. Therefore, if one sees the child without evidence of major pulmonary complications, the child is kept in reverse Trendelenburg position, lying on the right side for 12 to 24 hours prior to operation. This maneuver allows any secretions or aspirated material present in the tracheo-bronchial tree to gravitate toward the side which will subsequently be temporarily de-functionalized by operation. Should the child achieve diagnosis at a later stage, and one be presented with the major pulmonary pathology on the left side, then the preoperative posi-

tion of choice would be on the left, and the left side utilized for the operative procedure. The presence of the aortic arch and descending aorta on the left complicates the left approach, and when we have had to utilize this approach we have usually found it necessary to mobilize the arch by ligation of a variable number of intercostal arteries.

In all children presenting this abnormality, preoperative treatment with antibiotic drugs is an absolute necessity. Even if there are not striking findings of pulmonary disease, it is rare, if ever, that these children have a completely clean pulmonary tree. Furthermore, it is well to have an adequate amount of antibiotic material circulating in the blood at the time of carrying out the operative procedure. It is our practice to give these patients 30,000 units of penicillin every three hours intramuscularly for 24 hours prior to operation and also to give them 0.125 grams streptomycin intramuscularly at an eight hour interval.

Much attention has been paid in the literature to the factor of dehydration in these infants. We feel strongly that this aspect has been unduly over-emphasized. We are all cognizant of the greater tendency with which pulmonary edema may be produced in the patient in whom functioning lung volume is decreased by either atelectasis or pneumonia. Furthermore, there is increasing evidence being presented that the actual fluid requirement of the newborn infant in the first three to five days of life is much smaller than originally considered. In particular, in the premature infant it may not be necessary to give any parenteral fluid. If the child is not premature and is seen within the first 48 hours of life, then he is given one-half the expected fluid requirement in the 24 hours prior to operative procedure; if he is more than 48 hours of age then the full fluid requirements for one day are given in the 24 hour period prior to operation.

The factor of abdominal distention in these children has drawn considerable comment. Dr. Bigger has recommended that this aspect be controlled by a preliminary gastrostomy. Thus, he carries out a gastrostomy to deflate the gastrointestinal tract from 24 to 48 hours prior to the intrathoracic operative procedure. One cannot deny the apparent efficacy of this procedure on studying the results obtained by this method. However, it is our opinion that this abdominal distention, which is felt both to decrease pulmonary function and to increase difficulties of anesthesia, may be overcome if one passes the catheter utilized in the esophageal anastomosis down into the stomach and leave it in place until the completion of the operation. Then suction is applied to the catheter and the stomach deflated at the completion of the operative procedure. The only criticism to Dr. Bigger's recommendation is that gastrostomy may represent an unnecessary operative procedure. One must emphasize that Bigger only recommends gastrostomy when one is confronted with a tracheo-esophageal fistula communicating with the distal esophageal segment. If one does carry out a preliminary gastrostomy, there is an additional concern in regard to loss of electrolytes. Furthermore, if one can satisfactorily perform a direct end-to-end anastomosis, gastrostomy is not a necessary adjunct in the majority of patients. Adequate fluid and electrolyte balance may be maintained in these infants with a carefully controlled intravenous drip during the first five days postoperatively. However, the suggestion of Bigger merits serious further consideration and application to determine its real place in the therapeutic regimen.

There has been considerable discussion by various authors, relative to the role of preoperative therapeutic esophagoscopy and bronchoscopy in these infants. We believe that there is no argument relative to the true

advisability of an adequate cleansing of the upper esophageal pouch, preferably by means of endoscopic measures in all patients. Bronchoscopic maneuvers should, in all probability, vary with the indications in the individual patient. In the event that patients should be diagnosed late in the course of their disease, one is usually confronted with major degrees of atelectasis. In such a situation bronchoscopy soon after achieving the diagnosis is usually required.

Before concluding our remarks relative to preoperative management, it would be well to stress that a careful investigation be carried out in regard to the possible presence of other congenital abnormalities. Appropriate surgical attention should be paid to these matters, but in no instance do these other abnormalities require treatment prior to the attack upon the tracheo-esophageal fistula. The only possible exception to this rule appears to be when one is confronted with the coincident presence of a small bowel atresia. In such a situation, then it might be preferable to do a preliminary gastrostomy, and while in the abdomen carry out gastro-enterostomy as the first surgical procedure. This should be followed, in 24 to 48 hours, by direct attack upon the fistula. It is doubtful whether such infants should be subjected to primary end-to-end anastomosis of the esophagus.

Operative procedures

The surgical attack utilized in these patients appears quite well standardized at this time. It consists, fundamentally, of the method outlined by Cameron Haight in regard to primary end-to-end anastomosis. The methods suggested by Levin and Ladd should be utilized in those instances wherein a direct anastomosis is not possible.

There has been much discussion in regard to the method of anesthesia which should be utilized. Many authors prefer the use of local anesthesia. Others utilize local anes-

thesia along with ether by positive pressure mask insufflation. It is our preference to use novocain infiltration and positive pressure mask cyclopropane or cyclopropane-ether mixture. Some authors recommend the use of an endotracheal tube, particularly if they plan to utilize a transpleural approach. They suggest that this allows better access to tracheo-bronchial secretions and safer control of the positive pressure mechanisms. We cannot agree with this premise, particularly if there is a fistulous communication between the trachea and distal esophageal segment. Furthermore, the size of the endotracheal tube required decreases the efficiency of aspiration equipment. An endotracheal tube certainly increases the possibility of a postoperative tracheotomy being required. If an endotracheal tube is utilized, then one would strongly emphasize the value of the new Portex endotracheal tubes which have proven much less irritable to the trachea and subglottic tissues. Following any positive pressure method utilized, one must pay due attention to deflation of the gastrointestinal tract, postoperatively, whensoever the oral cavity is in continuity with the stomach during positive pressure maneuvers.

As has been mentioned, the right thoracic approach is usually the simplest. This is certainly true in all instances unless some abnormality of the aortic arch is present such as a vascular ring or right descending aorta. Abnormalities of the aortic arch do occur in conjunction with tracheo-esophageal abnormalities and have been encountered in four instances in our personal cases. Although a transpleural approach has been recommended by some, the majority recommend an extrapleural approach. We are in full agreement with this majority sentiment. We prefer to place the infant in a face-down position, with the face turned toward the operative side and the arm on the operative



Fig. 5. Photograph illustrating the scar resulting from the right parascapular incision most commonly used. This child had an upper blind pouch, tracheo-esophageal fistula to lower segment. Normal growth and development after primary end-to-end anastomosis. No postoperative complications.

side extended well beyond the head. We use a long, peri-scapular incision (see Fig. 5) very comparable to that utilized in thoracoplasty. The fourth rib is exposed and excised sub-periostally in its entirety. Disarticulation of the rib posteriorly has been recommended by Bigger as increasing the ease with which extrapleural dissection may be carried out. Furthermore, a small anterior stump of the rib lateral to the costochondral junction should be preserved, in order to facilitate extrapleural dissection. Extrapleural dissection is then carried out and the azygous major vein is identified, and may or may not require transection.

The vagus nerve is a very prominent structure in a newborn infant, and is quite helpful in localizing the position of the esophagus. After the esophagus is identified, the primary attention is paid to the segment with which the fistula into the trachea is formed. The fistulous connection is ligated close to the base as it inserts into the

trachea, making sure not to constrict the tracheal lumen. If the fistula is arising from the lower segment of the esophagus into the trachea, the esophagus is not transected immediately following ligation of the fistula.

Attention is next paid to the segment of the esophagus forming a blind pouch which, in the majority of cases, is the upper segment. This is identified and freed as completely as possible, all the way up into the neck and then drawn down, after which a decision can be made as to the feasibility of a primary end-to-end anastomosis. If this upper stump can be drawn without tension to within one centimeter of the point of origin of the fistula going into the lower segment, then a primary anastomosis may be carried out with safety as the lower segment can be elongated somewhat by further freeing of this lower segment down into the lower mediastinum. Extensive mobilization of the lower segment is not recommended, inasmuch as it may compromise the blood supply. The anastomosis is performed according to the method described by Haight.

As previously mentioned, a catheter is inserted into each end of the open esophagus prior to anastomosis and is inserted distally, sufficient to enter into the stomach. This maneuver is needed, both to rule out the possibility of obstruction in the lower esophageal segment and to allow evacuation of any air which is contained in the upper gastrointestinal tract. Following completion of the anastomosis and aspiration of contained gastric air, the catheter is removed. Allowing the catheter to remain is felt to increase the amount of secretions in the oropharynx, thus increasing the possibility of aspiration and decreasing the effectiveness of cough. In the earlier days of this operative procedure, it was a practice to place a drain down to the site of anastomosis and bring it out close to the posterior thoracic

wound. All authors have noted a very high frequency of postoperative pneumothorax utilizing this maneuver, and it is now a practice to place a mushroom catheter through the lateral chest wall under siphon suction, or, if the pleura has been inadvertently opened, the catheter is introduced directly into the pleural cavity. During the postoperative period the patient's hydration is closely observed, with particular attention not to over-hydrate the patient. It is not our practice to transfuse the patients during the operative procedure, but we routinely give a transfusion immediately upon completing the operation, usually in the amounts of 10 cc. per pound.

Particular attention, in the postoperative period, is paid to the hygiene of the oropharynx and decreasing the secretions in the oropharynx. Oxygen is usually given. The patient is frequently turned, and kept in a Trendelenburg position. On the fourth or fifth day a lipiodol swallow is carried out under fluoroscopic vision, and if a satisfactory lumen is present small feedings are begun. If we are not satisfied with the lumen of the anastomosis at the time of operation, or if there is any early evidence of leakage of the anastomosis, a gastrostomy is immediately carried out. In the earlier days of this operative procedure it was felt mandatory to carry out an end-to-end anastomosis wheresoever it could be considered, even if there were major liability to leakage at the anastomosis site. There has been a considerable swing of opinion in this regard, and it is now felt that unless a safe anastomosis can be carried out it is best purely to transect the fistula, adequately closing the fistulous ends of the esophagus and usually to carry out an exteriorization of the upper pouch, as well as a gastrostomy, all at the same operative procedure or at a twenty-four hour interval, should the patient's condition indicate the same. Postoperative strictures at

anastomosis site are most prone to occur in patients in whom there has been some leakage of the anastomosis or some infection about the anastomosis site. Chemotherapy is utilized liberally throughout the post-operative period.

Review of experiences

We wish to report briefly on our own series of 20 patients. It is interesting to note that 15 of the 20 patients were males. These infants varied in their birth weight from 4 lbs. 1 oz. to 9 lbs. 8 oz. The diagnosis was made at the age of 24 hours of life in only two instances. In five patients the diagnosis was made during the second day of life. One was diagnosed on the fourth day, and the remaining 13 patients were diagnosed between the seventh and tenth day of existence. One very unusual patient having an H-type of fistula without esophageal atresia was diagnosed at the age of six weeks.

In the majority of instances the patients were operated on approximately 24 hours after the diagnosis was achieved. In the few patients diagnosed in the first and second day of life, it was occasionally possible to carry out operation at a shorter interval following the formation of the diagnosis. In a little over half of the patients cyanosis and breathing difficulty was noted at the time of birth. In all patients in which feeding was attempted cyanosis and choking were noted. Salivation was a prominent symptom in all patients over 24 hours of life, but was present in some degree during the first day of existence. The degree of pulmonary pathologic changes varied fairly concomitantly with the duration of life. Eight of the 20 patients were noted to have coincident anomalies. In three of these patients the associated anomalies precluded any chance of survival.

The type of pathologic changes in the 20 patients showed that there were 16 in whom

the upper stump of the esophagus ended in a blind pouch, while the lower esophageal segment communicated with the trachea in 15 instances, and with the left mainstem bronchus in one. An H-type of fistula between the esophagus and trachea without associated atresia of the esophagus was found on three occasions. In one of this group there was an associated imperforate anus, and this had been operated on as the primary surgical attack, and we did not see this patient until the time of autopsy. There was one instance of a patient having a fistula between the upper stump of the esophagus and the trachea. The tracheo-esophageal communication was at the lowermost portion of the trachea just above the carina, or in the upper portion of the bronchus in all cases presenting associated atresia. In all three of the H-type fistulae, the fistula was two to three centimeters above the carina in the posterior wall of the trachea. In four instances a primary end-to-end anastomosis was not technically feasible.

In one of these having a communication between the upper esophageal stump and trachea there was a complete agenesis of the lower two-thirds of the esophagus. This patient was treated by ligation of the fistula, exteriorization of the upper esophageal stump, and associated gastrostomy, all carried out at the same time, and the patient has survived to the age of two years and two months in excellent condition. A photograph of this patient is presented in Figure 6. In the three other instances in which anastomosis was not truly technically feasible, an anastomosis was carried out under very severe tension by complete mobilization of the esophagus. Two of these patients resulted in fatality, while the third developed a leakage at the suture line with consequent empyema, which was handled by closed thoracotomy drainage. The patient subsequently produced a recurrence of



Fig. 6. Patient D. S., at age 23 months. Treatment consisted of closure of fistula between upper esophageal segment and trachea, cervical esophagostomy and gastrostomy. Patient had a complete agenesis lower two-thirds of esophagus.

the tracheo-esophageal fistula which may, in part, have been due to the presence of an indwelling tracheotomy tube. This tracheotomy had been required in the first few hours of life due to a severe traumatic edema of the larynx, secondary to unwarranted strong direct suction maneuvers. This patient was finally salvaged by a secondary transpleural operative procedure in which the recurrent fistula was transected and closed, and the upper stump exteriorized. A

gastrostomy had been done at the time of leakage of the suture line early in this patient's course. After a very stormy course this patient finally was able to have the tracheotomy removed and is now five months of age.

In five instances stricture at the anastomosis site occurred, in four of whom there had been evidence of leakage at the suture line during the postoperative period. In each instance it was possible to control the stricture by means of dilatation procedures carried out under direct vision through the upper esophagoscope, and a successful result was obtained. However, in one instance stricture could not be alleviated, due to very marked peri-esophageal fibrosis which not only distorted the course of the esophagus, but caused a constriction of the lower trachea, and it was necessary to do a secondary transpleural procedure and carry out a lysis of both these organs, with a subsequent successful result.

It has been of interest to us to note the constant improvement in mortality figures as these cases are studied in yearly groups. In the early years of this study no patient was seen prior to the age of six days, and usually was in a terminal condition at the time he was brought to the hospital. Even in these hopeless instances an attempt was made in every case to carry out a 24 hour preparatory period and to perform operation. A successful result, although extremely rare, made us feel that such an attack was justified. In later years with greater consciousness of this disease by the physicians in this locality, earlier diagnosis has been made, and with improvement in our methods of preoperative preparation and operative technic it has been possible to salvage nine of the last 12 operative cases (see Fig. 7). The three deaths in these last 12 cases were due, in two patients, to associated multiple severe anomalies such as both



Fig. 7. Patient, J. D., aged 26 months. Had usual type upper blind segment, fistula between trachea and lower esophageal segment. Treatment by primary end-to-end anastomosis at age 72 hours.

tetralogy of Fallot and duodenal atresia in one, and tetralogy of Fallot plus renal anomalies in another. The third case in this group died after an apparently completely successful procedure. Death was due to a severe uncontrollable infection occurring following the administration of subcutaneous Amigen diluted 1:4 with Ringer's solution. This method of administration has been recommended by pediatricians, but we have had three instances in this series of serious infection, one of which was fatal, and it is highly recommended that subcutaneous administration of Amigen, even in dilute form, should not be utilized.

Recurrence of tracheo-esophageal fistula occurred in two patients in this series, one of which was fatal and in the other a successful result was obtained after considerable further operative work. Except for the two patients having associated severe cardiac anomalies, all deaths were due to overwhelming pulmonary infection.

There has been considerable discussion

as to the advisable procedure to be carried out in patients in whom a primary direct end-to-end anastomosis cannot be accomplished. Several authors have suggested the use of a transpleural approach with the performance of a high esophago-gastrostomy. To our knowledge this procedure has been carried out in approximately 16 instances and has been fatal in 15. The application of this procedure is not advised. In a proper candidate there seems little reason to have a fatality in a patient presenting such a situation, if early exteriorization of the esophagus, closure of the fistula, and gastrostomy be carried out. Subsequent high esophago-gastrostomy can be carried out at a later date, preferably after the age of two years. The infant does not appear to tolerate the entire stomach within the thorax, and it would seem to us advisable that the procedure be carried out preferably around the age of five years.

It has been noted, in patients in whom the indirect method of operative correction has been utilized, that excellent weight gain may be obtained by special attention by the mother. This was brought to our attention in one patient in whom the mother insisted that the child develop a sense of taste and always fed him by mouth with the same material that was being given in the gastrostomy tube. It would appear that such a procedure seems to stimulate the gastric secretions and can be a helpful adjunct. In four instances anomalies of the aortic arch, involving recurrent subclavian arteries or right aortic arch with right descending aorta, had been found at the time of operation in conjunction with tracheo-esophageal fistula. In none of these patients was it necessary to carry out any special maneuvers directed at this vascular anomaly in order to obtain a satisfactory result.

Summary and conclusions

The subject of tracheo-esophageal fistula

and tracheo-esophageal atresia has been discussed. The historic and embryologic aspects of this abnormality are noted. There is still no doubt but that a great number of these patients die without this abnormality being diagnosed. A greater awareness by the profession of the possibility of this lesion should result in a considerable improvement in the salvage rate involving these patients. Under no circumstances should these lesions be treated by gastrostomy if one is planning to utilize the gastrostomy for feeding, but Bigger's principle of a gastrostomy as a method of deflation of the gastrointestinal tract may prove to be a valuable adjunct to direct attack upon the fistula 24 hours later. The symptomatology of this lesion has been stressed. Fundamentally, the symptomatology consists of a frequent instance of respiratory difficulty at birth. Excessive salivation is noted early in the infant's existence. Choking, cyanosis, and regurgitation will occur with the first attempts at feeding unless an H-type of fistula is present. This latter type of fistula may produce a different syndrome, and these aspects are described.

Suggestive physical signs consist of salivation and pulmonary moisture. The diagnosis may usually be made by the passage of a soft rubber catheter under fluoroscopic vision. Contrast media need rarely be used and, if used, must be utilized in very small amounts and consists only of from 0.5 to 1.0 cc. of lipiodol. The tendency of these patients to show abdominal distention and x-ray evidence of excessive gastrointestinal tract air has been noted. The presence of air in the gastrointestinal tract predicates a fistulous communication between the trachea and distal esophageal segment, while an absence of air predicates a fistulous communication with the upper esophageal segment.

Once the diagnosis has been made, it may

be advisable to utilize twenty-four hours of preoperative preparation. The major factors in preoperative preparation consist of cautious administration of fluids with assiduous avoidance of over-hydration. Chemotherapy is required. Measures advised in regard to pulmonary hygiene in the preoperative period have been described. The operative measures have been discussed.

Our experience has shown that in only three instances out of 20 patients did we encounter associated anomalies of sufficient severity to contraindicate the possibility of salvage. With increasing experience one has tended to decrease his insistence upon a primary end-to-end anastomosis unless the situation appears completely satisfactory for this procedure. We have not had experience with the application of Dr. Bigger's principle of preliminary gastrostomy, although in three instances the patient has arrived in our hands with a gastrostomy already in place. In all three instances previous attempts at feeding through the gastrostomy had been carried out, so that in no way could these patients be considered a trial of this recommendation. We have felt that a general tendency toward abstaining from the use of any contrast material other than the passage of a soft catheter has improved the pulmonary condition with which we are confronted at the time of operation. We have been very impressed by the value of Dr. Haight's recommendation of keeping the patient upon the side of proposed operation for 24 hours prior to surgery. We do not feel that a diagnosis of tracheo-esophageal fistula with esophageal atresia predicates an emergency operative procedure. If any evidence of pulmonary disease is present, we prefer to utilize 12 to 24 hours of preparatory measures, as described. When confronted with patients in whom diagnosis is made within the first 48 hours of life and in whom the pulmonary status appears nor-

mal, then we do feel that very immediate operation is indicated.

1. Congenital abnormalities of the trachea and esophagus need not be considered a rarity.
2. Although this lesion may co-exist with other anomalies, it is felt that in less than 20 per cent of instances do concomitant anomalies preclude the possibility of worthwhile salvage.
3. All infants with esophageal atresia and tracheo-esophageal fistula die from pulmonary complications unless surgical correction is achieved.
4. The chances of salvage by surgery decrease proportionate to the delay in achieving the diagnosis and the degree of secondary pulmonary contamination.
5. Any infant showing prolonged respiratory difficulty at birth, excessive salivation, cyanosis on feeding, regurgitation of the first feedings, should be studied by passage of a catheter under fluoroscopic vision.
6. The hazards of x-ray contrast media require care and thought in their use.
7. The danger of over-hydration of these infants is stressed.
8. Eighty per cent of these infants may be salvaged by combining early diagnosis, adequate preoperative management, and the proper type of surgical procedure required in the individual case.

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FASCIOTOMY IN TREATMENT OF GRAVITATIONAL LEG ULCERS

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Victims of leg ulcer, especially of the type here discussed, have been a headache to the medical profession in the past and anything that promises help is more than welcome. At the St. Louis meeting of the International College of Surgeons in 1948, it was our privilege to hear an illustrated paper on this subject by Dr. H. Kelikian, Associate Professor of Orthopedic Surgery, Northwestern University Medical School. Dr. Kelikian's paper was so practical we were moved to contact him after the meeting for further details. Further acquaintance with him resulted in our visiting him in Chicago, and later in his making a special trip to Thomasville, to talk before our Thomas County Medical Society. By this time we had had occasion to follow his technique on a dozen patients with chronic leg ulcers. So, it is our pleasure here and now to express our appreciation to Dr. Kelikian for the ideas in this paper and for the loan of the slides illustrating it.

The very fact of the number of men and women who seek relief from chronic and recurring leg ulcers, and who drift from clinic to clinic, is ample evidence of our failure to give more than passing relief. Most of these patients have had injections, ligations, salves and elastic supports, but continue to haunt doctors offices. To quote Dr. Kelikian, "Stagnation, as the cause of gravitational ulcers, may result from lack of muscular activity and movement, as in

Read before the Medical Association of Georgia in annual session, Macon, April 20, 1950.

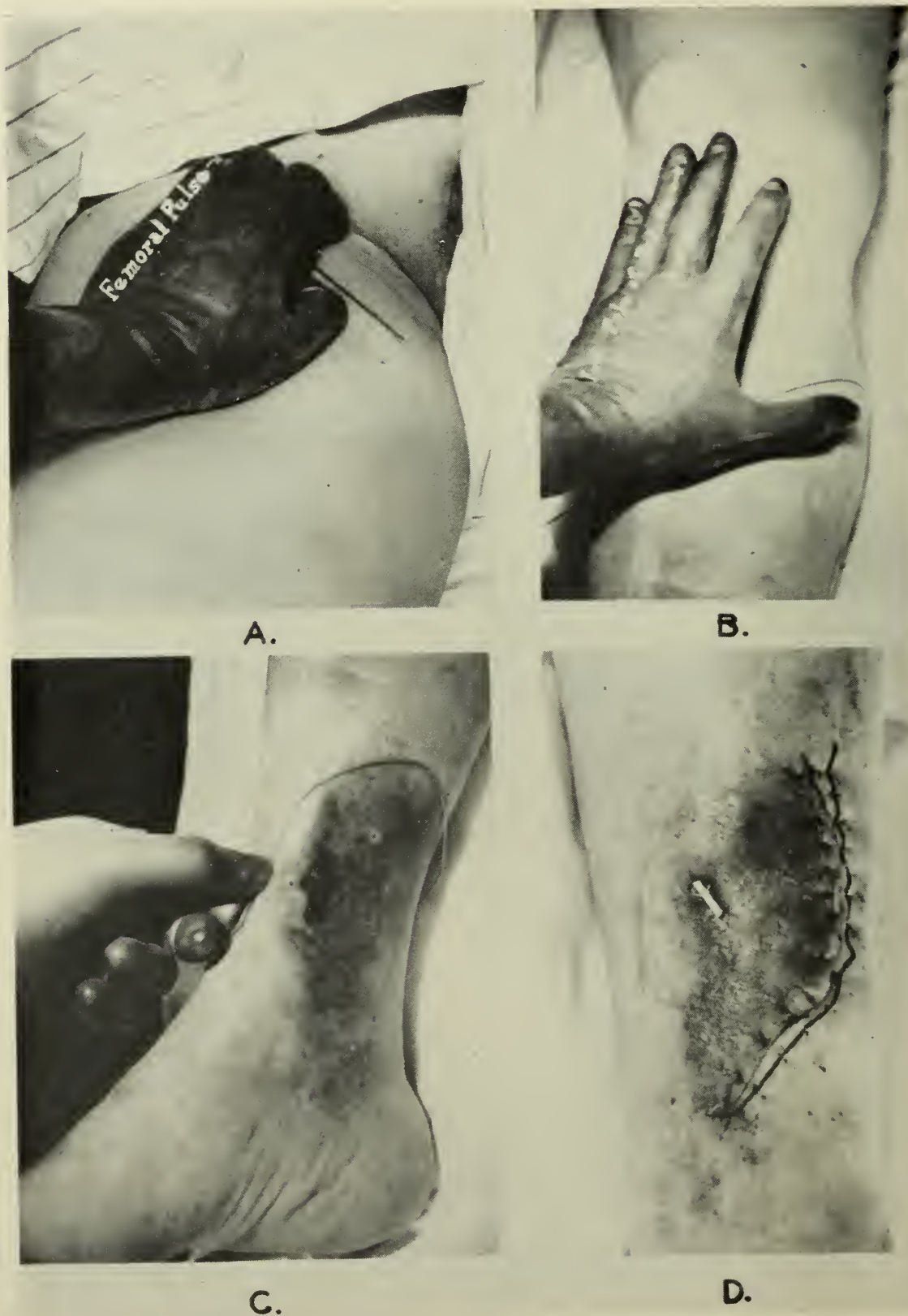


Fig. 1. Allocation of incisions for the patient's right leg. (a). Incision in the groin. (b). Incision below the bend of the knee. (c). Incision for the proximal polar insulation of the ulcer. (d). Secondary incision to completely circularize the ulcer-bearing area and slip a fascial flap under the adherent scar.

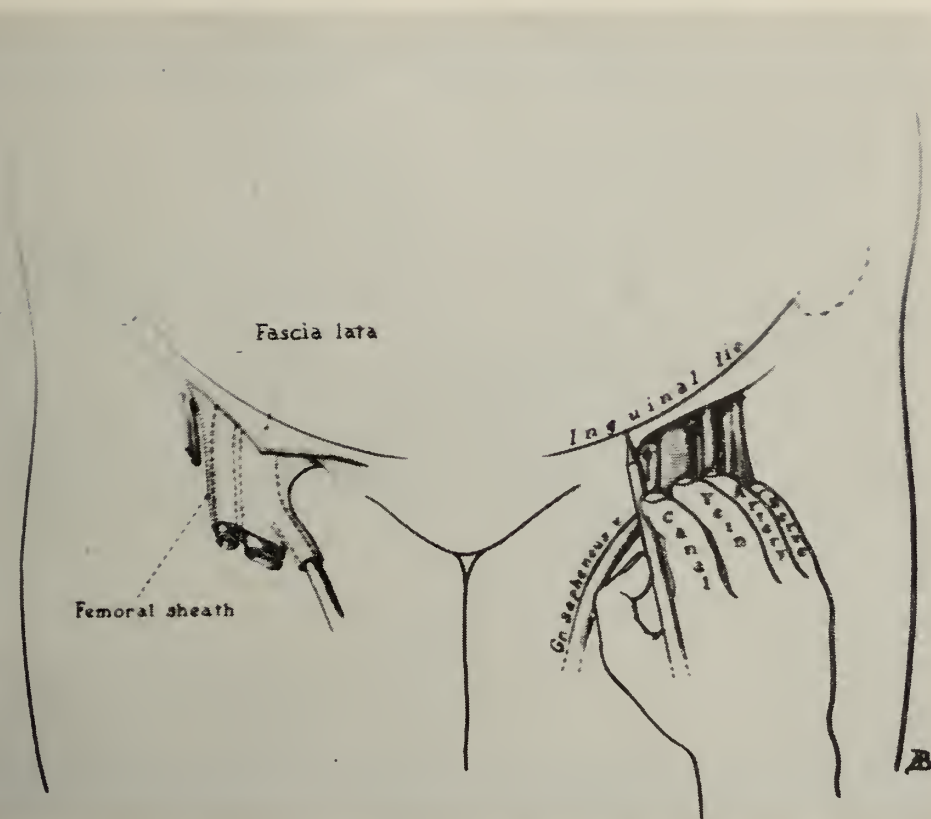


Fig. 2. This drawing depicts on the right side of the anatomical relations of the long saphenous vein in the groin its connection to the femoral vein, and through the femoral sheath, to the artery. Throughout its course from the foot up to the groin the long saphenous vein lies within the loose superficial fascia. In the groin it pierces the deep fascia to connect with the femoral vein underneath it and thus establishes for itself a point of fixation. Since the femoral vein in its turn is bound to the femoral artery by a common fibrous sheath, the long saphenous becomes linked to the artery indirectly, though firmly. The terminal segment of the long saphenous vein can best be localized in relation to the femoral pulse, the most dependable landmark in the groin. On the left side in the drawing a method is suggested for localization of the segment of the saphenous vein to be ligated. If the left groin is to be explored, as indicated in this drawing, the surgeon palpates with his right hand. Sinking his ring finger into the patient's groin, just below the inguinal crease, he locates the pulsation of the femoral artery, about midway between the anterior superior spine of the ilium and the pubic crest. Having localized the femoral pulse the surgeon places his ring finger over it. He then pivots his hand around this digit and places it into the position of writing with an imaginary pencil along the inguinal crease. The femoral nerve, which lies lateral to the artery, streams down towards the surgeon's small finger; the femoral vein on the medial side of the artery passes under the pulp of the long finger; the index points towards the femoral canal and the distal phalanx of the thumb pressing the imaginary pencil against the second and third fingers marks the direction of the terminal portion of the saphenous vein.

arthritis with two or three stiff joints. More commonly it is caused by reverse flow of venous blood and is associated with varicosities of the veins of the leg." Since the deep veins of the leg are all located within the confines of the crural fascia and benefit from the squeezing action of muscular contraction, stagnation is rare.

Being limited as to time for this presentation, it must suffice to say that the real

cause of gravitational leg ulcers lies in the anatomic structure between the deep and superficial veins. Those veins lying outside the crural fascia, lacking the massaging effects of muscular action, become dilated up to the point of entrance to the deep fascia. These varices do not extend into the deep fascial annectant veins, nor does inflammation except on rare occasions. The lymphatics accompany the different veins and

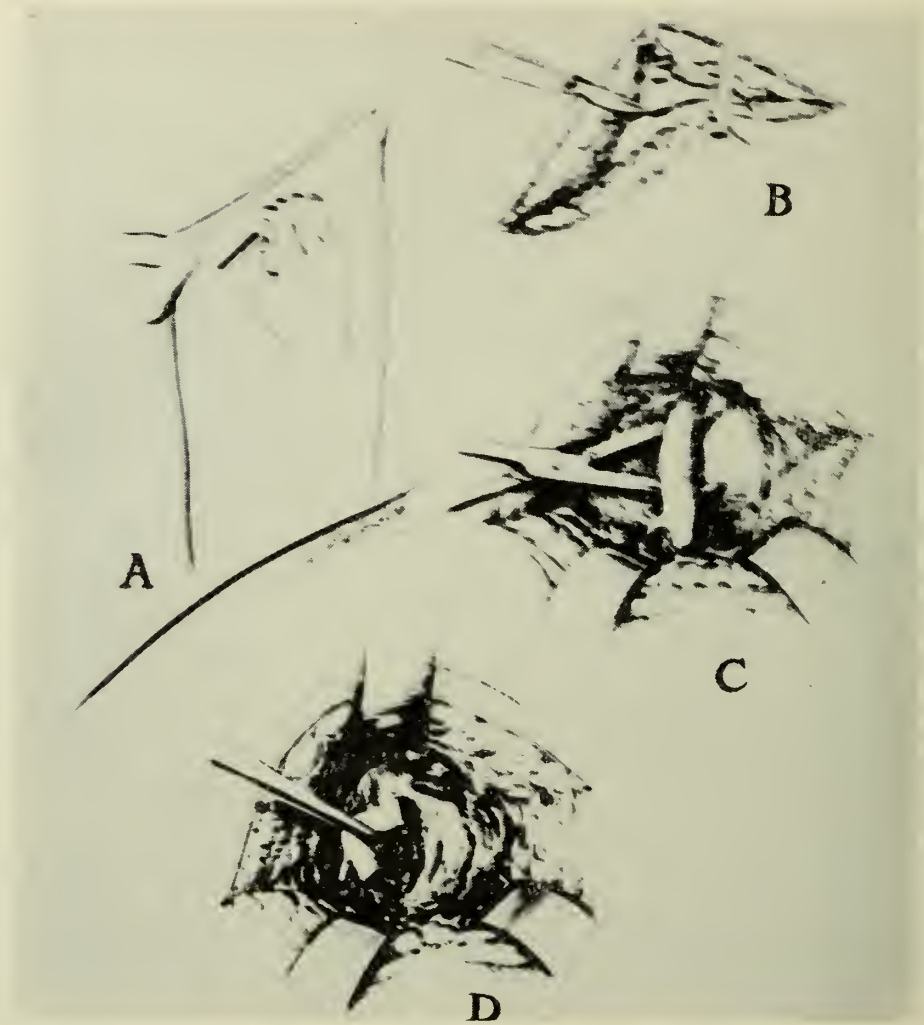


Fig. 3. Composite drawing showing the main steps of high saphenous ligation: (a). Skin incision parallels the dorsum of the thumb flexed from the position of holding an imaginary pencil against the index and the long finger of the surgeon's palpating hand. The incision falls in line with the skin crease normally found in this region. (b). When the incised skin edges are held up, the saphenous vein falls on the deep fascia which it enters the joint with the femoral vein underneath it. Holding the skin edges up with non-crushing forceps the surgeon cuts the interval sharply, with impunity. (c). The surgeon then sinks a blunt forceps at one and then the other corner of the incision until the tip of the forceps meets the resistant deep fascia. By spreading the blades of the dissecting forceps apart he clears the saphenous vein of its surrounding areolar tissue. The forceps is now passed under the vein preferably from a lateral to a medial direction and the vein is lifted out of the wound. (d). The vein is doubly ligated above and below and the segment between the ligatures is resected.

are affected in large measure by the same conditions that produce stasis in the veins. Wherever there is reverse blood flow in veins due to incompetent valves, and resultant stasis, the lymphatics suffer from the same type of stasis. Since there is little doubt that gravitational leg ulcers are caused by stasis of the superficial veins, principally the long and short sapheni, the question is what to do about it. The deep or crural

fascia contains the muscles of the leg. The vessels inside this fascia are assisted by the massaging action of the contained muscles, whereas the vessels lying between the fascia and skin have no such help and suffer stasis. Removal or loosening of this sleeve of fascia allows the muscular contractions to lend their beneficial pumping support to the remnants of superficial lymphatics as well as to the veins. Extirpation of the fibrous matting

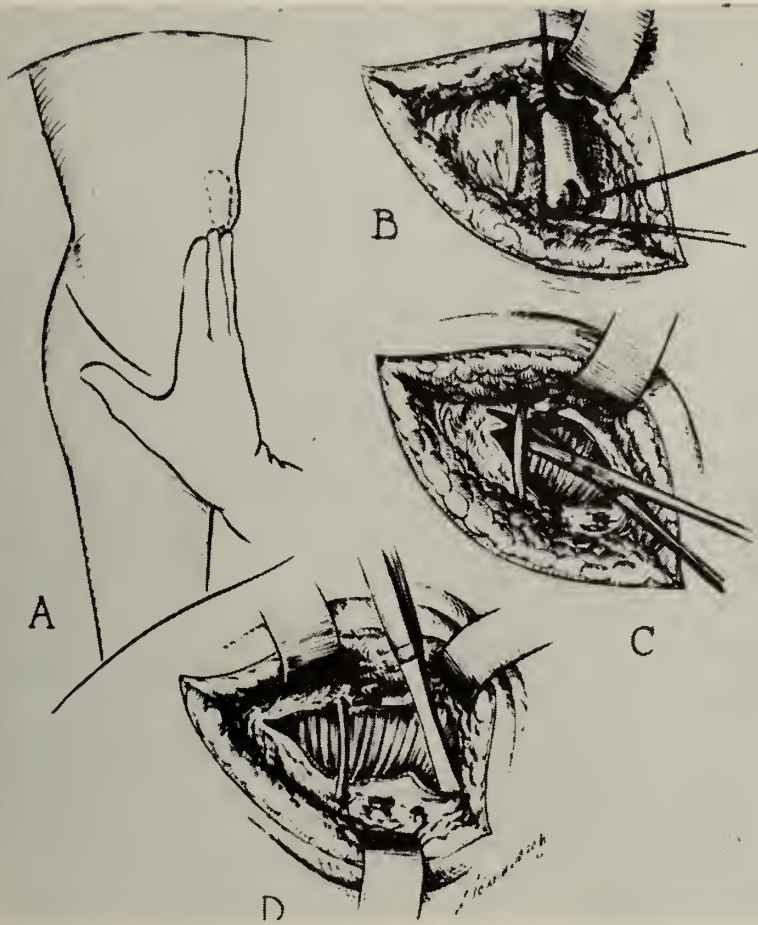


Fig. 4. Drawing of the incision below the bend of the knee. This incision as others in the leg serves the dual purpose of vein ligation and fasciotomy. Using again his contralateral hand (his right in this drawing) for palpation the surgeon applies the tip of his ring finger to the inferior pole of the patella and allows his hand to rest on the front of the proximal leg. (a). The incision to locate this portion of the saphenous vein and at the same time to slit the deep fascia underneath it parallels the volar surface of the surgeon's abducted thumb. (b). The saphenous vein and its smaller tributaries are ligated. The saphenous nerve which comes down from Hunter's canal lies on a deeper plane and somewhat posterior to the vein. It is isolated and preserved. (c). The crural fascia overlying the origin of the flexor group of muscles and medial belly of the gastrocnemius is widely slit. (d). The fascia is stripped away from the medial border of the tibia.

around the ulcer itself permits muscular tissue to come in direct contact with the avascular skin.

Treatment

Three main factors have to be realized.

1. Breaking the long column of blood in the saphenous system into smaller segments.
2. Sidetracking the flow of lymph from the fibrotic subcutaneous space into the healthier muscular compartments of the leg and at the same time removing the barrier

between these two chambers, so that the muscles can lend their beneficial squeezing action to the superficial vessels.

3. Pressure dressings to offer the ulcer rest and the limb uniform support.

In the first instance we practice high ligation of the long saphenous, using the stripping method now in use at the Mayo Clinic. This consists in dividing the great saphenous high and threading a braided wire with a marble-sized lead mass at one end down the

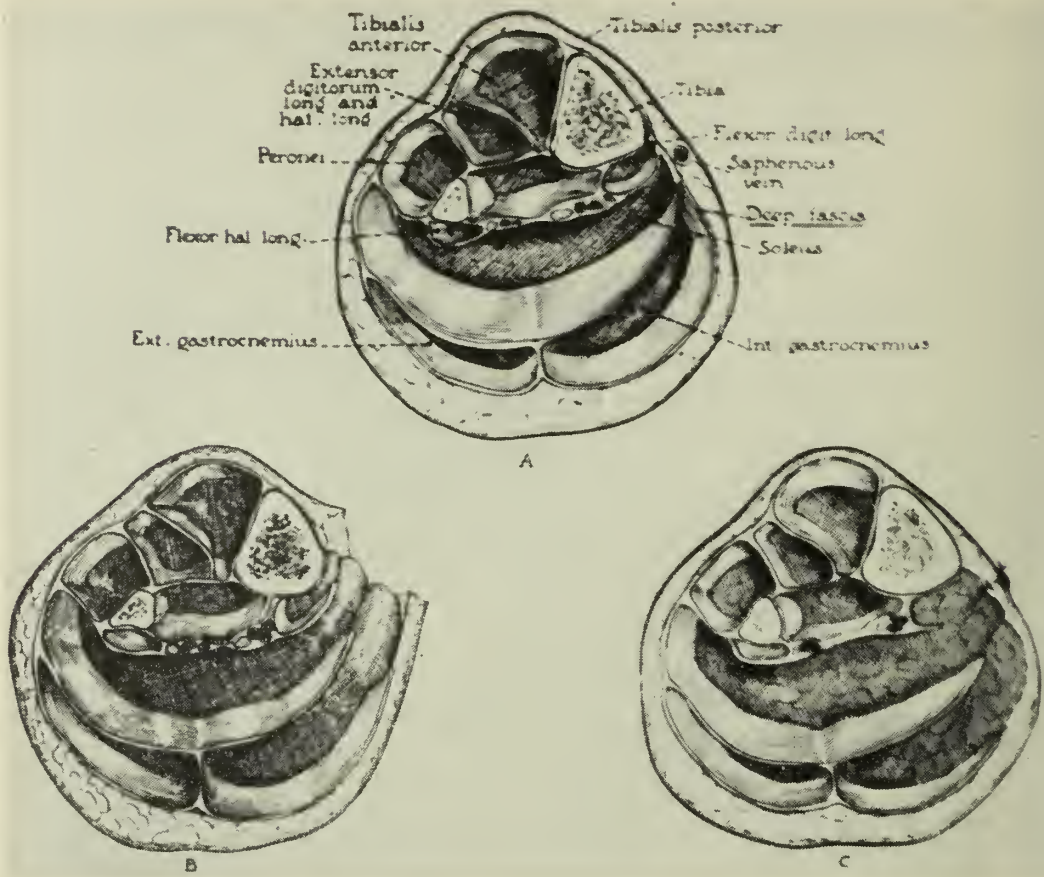


Fig. 5. Drawing which attempts to depict crural fasciotomy in cross section. (a). Section through the leg slightly below the level of the preceding incision showing various fascial compartments (redrawn from J. M. Bourger's *Iconographia D'anatomia Chirurgia E Di Medicina Operatoria*. Florence, 1841). (b). Indicates removal of the fascia over the medial belly of the gastrocnemius and the flexor muscles and extirpation of the septum between these two compartments. (c). Closure; only the skin is sutured.

vein as far as possible, then cutting down on the beaded lower end and simply turning the vein inside out by pulling the wire down from the divided area above. From here another stripping may be done still lower down. Again quoting Dr. Kelikian, "After high ligation, the saphenous vein is picked again below the bend of the knee, distal to where it sends a communicating branch to the short saphenous and the popliteal vein. Using right hand for left leg and vice versa, for palpation, the surgeon locates this point as follows: With the tip of the ring finger

touching the inferior pole of the patella, the palm is allowed to rest on the front of the proximal tibia with the thumb in abduction. An incision is drawn parallel to and a finger's breadth above the volar surface of the surgeon's thumb resting on the patient's leg. This incision is in line with the normal skin crease below the knee. It starts at the inner border of the tibia and ends over the medial belly of the gastrocnemius. The incision is deepened down to the fascia and the saphenous vein is dissected out. The vein passes obliquely from behind the region

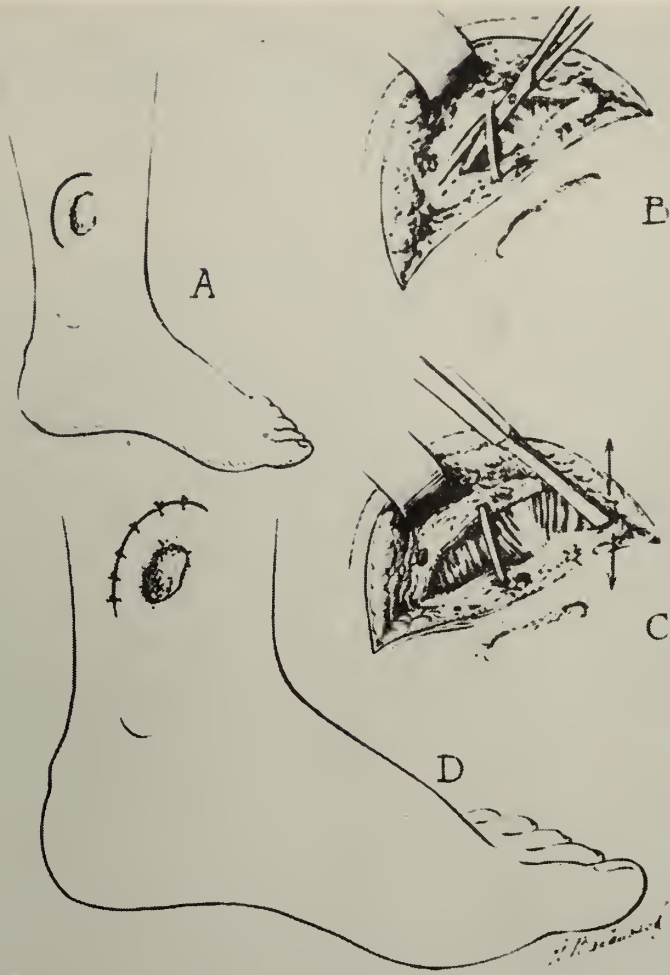


Fig. 6. Partial insulation of the ulcer-bearing area. (a). An incision, somewhat semicircular, is drawn around the ulcer, about a centimeter above and behind its indurated border. (b). All the veins leaking into the ulcer by reverse flow are doubly ligated and cut between the ligatures. If the ulcer is painful and the saphenous nerve is found scar-bound, the nerve is severed. Otherwise the saphenous nerve is left undisturbed and the crural fascia under it is slit transversely. (c). The deep fascia is then stripped up and down from the medial border of the tibia. (d). Only the skin is approximated. The skin in this potentially infected area is preferably sutured with wire.

of the medial condyle of the femur towards the inner border of the proximal tibia. The saphenous nerve traverses behind the vein closer to the deep fascia. It need not be disturbed. The vein is caught, ligated and divided.

"Fasciotomy is initiated through the preceding incision below the knee at the same sitting." Below the knee the short saphenous vein is ligated and the crural fascia

divided as follows: The deep fascia overlying the medial head of the gastrocnemius is slit wide open and the muscle belly is allowed to bulge into the subcutaneous space. The fascia is separated from the tibia as far down as the incision permits, and then another incision is made about the middle of the tibia and the fascia stripped from there in both directions up and down.

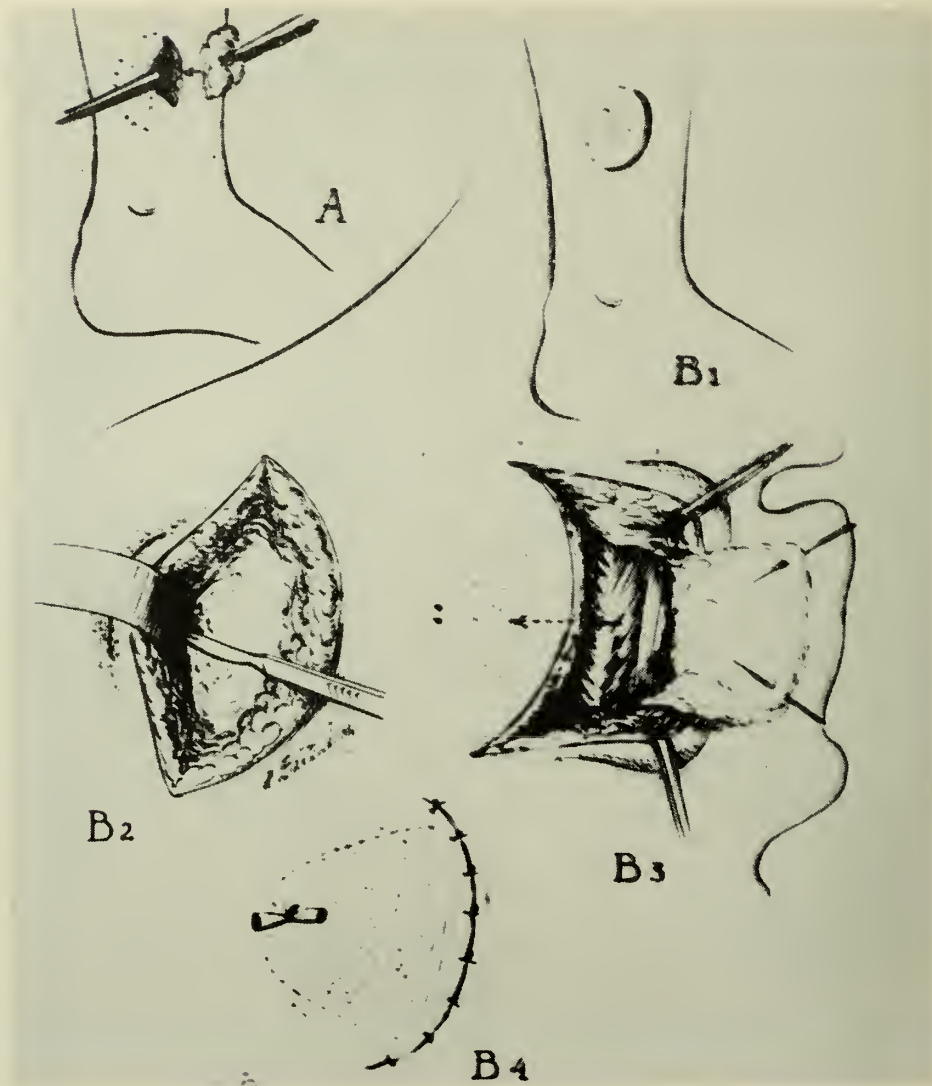


Fig. 7. Refinements. Three or more months after the ulcer has completely healed, several operative procedures are resorted to in an attempt to pad adherent, painful or pruritic scars. (a). Demonstrates feeding of a small morsel of free, autogenous fat through a small slit around the margin of the healed ulcer. (b₁). Indicates the incision for underlining the scar with a fascial flap. (b₂). Shows undercutting and lifting of the previously adherent scar. (b₃). A pedicled flap is prepared from in front of the leg utilizing the fascia which covers the extensor muscles of the toes and tibialis anticus. Its free lateral margin is secured by two needles bearing the same thread. (b₄). The fascial flap is turned medially over its attached border; it is flattened and adjusted under the lifted scar; the needles are then passed outside the skin and the anchoring suture is secured to a rubber tubing at the base of the lifted scar. The skin is closed over the underlying fascial flap.

We have used the technic described by Dr. Kelikian as follows: After fasciotomy is done the ulcer is insulated at the same sitting, by drawing a semicircular incision around the proximal pole of the ulcer, about a cm. from its indurated border. The incision cuts through skin and deep fascia severing and ligating all veins that lead to the ulcer. The deep fascia is then lifted by a periosteal stripping from the medial bor-

der of the tibia, up and down, as far as the incision will allow. Depending on the viability of the skin edge on the side of the ulcer, it is under cut and the thick fascia underneath is removed. Only the skin edges are approximated with interrupted sutures and the wound dressed with fine mesh gauze and pressure bandage.

At times when the ulcer overlies tendons or bony prominences it heals with an ad-



Fig. 8. Case 12. Stasis ulcer in an extremely obese woman. Aged 64. The body weight without clothes has varied from 340 to 389 pounds. At the time of the surgery, it was 354 pounds. Electrocardiogram revealed myocardial heart disease with bundle branch block. The duration of the ulcer was five years, and it had been, as other ulcers over the lateral aspect of the leg, excruciatingly painful. Previous treatments: Periodic rest in bed and topical applications of penicillin and cod liver oil ointment; also medicated ace bandages. (a). Left profile of the body as a whole. (b). Close-up view of the ulcer over the lateral aspect of the left leg. (c). Shows incision for proximal polar insulation of the ulcer and for crural fasciotomy. (d). Frontal view of the left showing the extent of the incision both medially and laterally and its closure with wire sutures which are tied over a strip of umbilical tape. (e). Medial view of the leg, showing the inner limb of the healed incision. (f). Lateral view of the leg two months after fasciotomy showing complete healing of the ulcer.

herent scar. It may cause contracture or pain. Cutaneous nerves traversing the scar may have to be cut. There may be other veins around the uncut border of what was once ulcer; these may keep the thin scarred skin moist and itchy.

Six weeks or more after this operation it may be then expedient to complete circularization of the ulcer through skin and deep fascia and undercut it so as to sever any possible communicating veins which might

feed the region by reflux. It is possible to underline the scarred skin with a fat bearing fascial flap or free grafts of subcutaneous fat. After this stage of surgery the principles of compressive boot or cast are applied and carried on until firm healing of skin edges is effected and swelling of ankle joint abated.

Ambulation is carried on as early as is consistent with pain and general feeling of well being.



Fig. 9. Case 8. One healed, one recurrent ulcer overlying the flexor compartment of the lower leg. Woman. Age 58. Duration of ulcers: Four years. Previous treatments: X-ray exposures and sulfa drugs. (a). Shows the lower leg just before segmental vein ligation and crural fasciotomy. (b). Three days after surgery. (c). Two months later. The ulcer healed with an adherent scar which required refining surgery in the form of underlining the previous ulcer bearing area of skin with a fascial flap. (d). Two months after fascial padding.

While this is a small series of cases, each and every patient had undergone treatment for several years and were still crip-

pled. From the gratifying results obtained, we feel that the method deserves a much wider use.

LESIONS OF THE SHOULDER

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The majority of shoulder lesions are lumped under the term "bursitis". In reality, primary subdeltoid bursitis, *per se*, is a rare entity and as generally employed, is a misnomer. Equally misleading terms in common usage are periarthrititis, neuritis, tendonitis, and calcified bursa.

As Codman and others have pointed out, the majority of shoulder lesions are degenerative and/or traumatic in origin; and the anatomic site of the primary pathologic process is most often found within the tendons of the scapular muscles; e.g., the tendons of the supraspinatus, infraspinatus (and teres minor), and subscapularis muscles which together form a tendinous hood or cap on the head of the humerus.

These degenerative and/or traumatic lesions may be noted as areas of large or small tendon rents or tears, fibrillations of tendon fibers, focal areas of hyaline or calcific degeneration within tendon tissue, and fibrous tissue replacement of tendon fibers. Rarely, pathologic evidence of a focal inflammatory process within tendon substance is noted; likewise, evidence of an inflammatory process involving the biceps tendon sheath, e.g., tendosynovitis, is rarely seen.

Secondary pathologic involvement of tissues adjacent to the tendinous hood—for example, the glenohumeral ligaments, articular hyaline cartilage, and overlying bursal sacs—may be, and frequently is found, but these secondary lesions are not of primary importance, especially in regard to therapy.

Shoulder lesions manifest themselves by pain, limited joint movements, muscle spasm, and areas of tenderness. The tender area most often delineated by the patient is near the insertion of the deltoid muscle; however, pain and tenderness may be extreme and may be found extending from the region of the upper trapezius muscle to the finger tips.

The shoulder movements showing greatest restriction are *abduction* and *external rotation*, as performed in placing a hand to the posterior neck region.

Novacaine infiltration and pneumoarthrography of the shoulder may be helpful as diagnostic adjuncts.

Shoulder lesions are seen most frequently in patients over 35 years of age. Under 35 years of age, there is usually a definite history of single or oft-repeated trauma associated with the onset.

Treatment of shoulder lesions should be conservative in the majority of cases. Time heals most shoulder lesions. Alertness to the serious secondary changes of disuse muscle atrophy and *adduction contracture* must be maintained, however, if the evidence of treatment failure—"frozen shoulder"—is to be avoided.

Graduated and guided active muscle exercise is the most useful single conservative therapeutic aid. Massage, heat, etc., are of less importance. X-ray therapy occupies an intermediate and ill-defined status at present. Manipulation is mentioned only for condemnation since unpredictable tearing of tissues is inevitable.

Curative therapy for approximately 20 per cent of shoulder lesions is surgical. These procedures include: (1) needle evacuation of calcium deposits under x-ray guidance, (2) tenorrhaphy for serious tendon tears or avulsions, (3) excision of calcium deposits in extremely painful cases, or in cases of less severity where conservative

therapy is failing, and (4) major surgical reconstruction consisting of excision of the acromion, transplantation of a cuff segment (Jones operation), and transplantation of the tendon of the long head of the biceps; this surgical therapy is reserved for the frozen shoulder.

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MELANOMA

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and

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This paper is written with the primary intent of analyzing our clinical experience with melanomas in the Robert Winship Clinic. To date 129 patients with a proven microscopic diagnosis of melanoma have been seen.

Table 1 and Figure 1 show the body dis-

Body Distribution of Melanomas

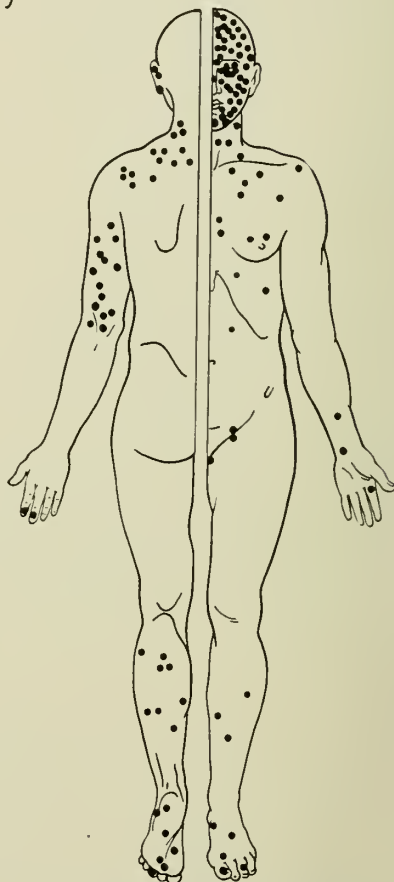


Fig. 1. Body distribution of melanomas.

TABLE 1
Body Distribution of Melanomas According to Various Investigators

	Winship Clinic	Sylvén ¹	Webster ² et al	Price ² et al	Ackerman ⁴	Pack ⁵
Head and Neck	37.9	33.6	25.9	37.0	32.0	25.7
Trunk	18.7	26.3	17.3	23.0	24.0	17.9
Upper Extremity	14.9	8.4	14.8	7.0	9.0	13.7
Lower Extremity	19.8	31.0	31.5	23.0	35.0	27.0
Genitalia	0.8	0.3	0	0.1	0	4.0
Eye	3.1	0	0	3.0	0	8.6
Unknown	4.8	0	10.5	0	0	0
Expressed in per cent						

tribution of melanoma diagrammatically and statistically. A little over $\frac{1}{3}$ of the melanomas treated in the Winship Clinic were located on the head and neck with the lower extremity, trunk and upper extremity in consecutive order. The figures generally agree with the findings of other investigators.

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†From the Robert Winship Memorial Clinic, Emory University School of Medicine.

Read before the Medical Association of Georgia in annual session, Macon, April 20, 1950.

Table 2 correlates the survival rates with body distribution of melanoma and indicates that the greatest survival rate appeared in the head and neck distribution. The trunk shows the least number of five-year survivals.

There is a marked difference between the survival rates for those who have metastases at the first visit and those who do not. The patient without metastases at the first visit

TABLE 2
Survival Rate Related to Body Location and the Presence of Metastases

	Five Years		Three to Four Years		Less Than Three Years		Totals
	With Metast. 1st Visit	Without Met. 1st Visit	With Metast. 1st Visit	Without Met. 1st Visit	With Metast. 1st Visit	Without Met. 1st Visit	
Totals	23	19	8	22	23	34	129
Head and Neck	1— 4.3%	3—15.7%	1—12.5%	5—22.7%	3—13.0%	12—35.1%	25—19.4%
Trunk	0	1— 5.3%	0	1— 4.6%	1— 4.3%	6—17.4%	9— 7.0%
Upper Extremity	0	1— 5.3%	0	3—13.6%	3—13.0%	1— 2.8%	8— 6.2%
Lower Extremity	0	0	0	4—18.1%	2— 8.7%	2— 5.7%	8— 6.2%
Genitalia	0	0	0	0	0	0	0
Eye	0	0	0	1— 4.6%	0	0	1— 7.7%
Totals	1— 4.3%	5—26.3%	1—12.5%	14—63.6%	9—39.0%	21—61.0%	51—39.5%

TABLE 3
Survival Rates Related to Metastases

		No.	N.E.D.*	Alive with Melan.	Died of Melan.	Died Other Cause	Lost	Survival in relation to groups	
Five Years or More	With Metast.	23	0	1 4.3%	21 91.4%	0	1 4.3%	1 4.3%	14.6%
	Without Metast.	19	4 21.0%	1 5.2%	12 63.4%	1 5.2%	1 5.2%	5 26.3%	
Three to Four Years	With Metast.	8	1 12.5%	0	6 75.0%	0	1 12.5%	1 12.5%	50.0%
	Without Metast.	22	10 45.4%	4 18.2%	6 27.2%	1 4.6%	1 4.6%	14 63.6%	
Less Than Three Years	With Metast.	23	5 21.5%	4 17.4%	13 56.7%	0	1 4.4%	9 39.0%	52.0%
	Without Metast.	34	19 56.0%	2 5.9%	9 26.4%	1 2.9%	3 8.8%	21 61.0%	
Totals		129	39	12	67	3	8	51	
Per cents		100	30.2%	9.3%	52.0%	2.3%	6.2%	39.5%	39.5%

*No Evidence of disease

had a far better chance for survival than those with metastases. In Table 3 the survival rates for the patients who had metastases at the first visit are 4.3 per cent for the five-year group, 12.5 per cent for the three to four-year group, and 39 per cent for the less than three-year group against the 26.3 per cent, 63.6 per cent, and 61 per cent for those patients who did not have metastases at the first visit.

In this series of cases, sex distribution shows 64 females to 65 males. Greatest incidence was between the ages of 30 and 60, the youngest patient was 7 and the oldest 86. The spread in the third to sixth decade in our cases with only three cases in the prepubertal age group indicates that this

disease is found primarily in the adult middle age group. Except for the prepubertal group, the age at which the lesion appears had no effect upon the ultimate prognosis. Our experience is in agreement with that of other investigators and all evidence indicates a much more favorable prognosis if the disease is treated before puberty. The three prepubertal cases are all living with no evidence of disease.

The color of the lesion appears to have no definite influence on prognosis. The black and bluish-black lesions are approximately the same in number. Very few non-pigmented lesions are in this series.

The small, superficial, non-invasive lesion shows the best prognosis. The size of the

initial lesion within limits of one to three centimeters has no definite bearing on the prognosis. The large, fungating lesions did very poorly. In 35 per cent of the lesions ulceration was present at the first visit. In this series, 24 per cent show no evidence of disease for the ulcerated group as compared with 38 per cent with no evidence of disease in the non-ulcerated group. Ulceration of the lesion present at the first visit shows a poor prognosis. Trauma appears to be the most consistently remembered factor by the patients. Seventy-five per cent of the patients can recall some remote trauma to the lesion. However, those lesions which had been allegedly traumatized previously showed essentially the same clinical course as those which had not been traumatized.

The presence of metastases at the first visit is found to be an important prognostic factor since these patients always do worse. This fact is borne out by our survival rates. Melanomas metastasize early by the lymphatics as well as the blood stream. The prognosis with metastases present at the first visit is poor but not hopeless. The patient with a lymph node metastasis has a slightly better prognosis than one who has a blood borne metastasis.

Just as the clinical and gross appearance of melanomas present considerable variation, the histopathology of the malignant mole is even more varied. It is impossible from the gross appearance of these tumors even to speculate as to microscopic structures. Many varied histologic types are described depending upon the predominating cell form, arrangement, or general character, such as epithelioid, spindle, mixed, giant, alveolar, non-pigmented, etc. It must be remembered that many and frequently all of these types and general features may be found in different parts of the same tumor and not infrequently in the same section. It should be emphasized that there are

many borderline pigmented tumors which cannot be definitely diagnosed as malignant melanoma but which still show evidence of activity and make one hesitate to place them in the group of definitely benign moles. There is much disagreement amongst pathologists about this type of tumor, where time alone determines its true character. In the meantime, the surgeon and the patient are faced with the serious uncertainty of prognosis and therapy.

In this discussion an effort has been made to divide the tumors studied into four groups based upon the cellular histopathology. All of the cases have been restudied and borderline or doubtful melanomas have been excluded.

We have divided the available tumors into epithelioid, spindle, mixed, and giant cell types. This is not any attempt at classification of these tumors. Other microscopic features have been considered such as the superficial character of some of the lesions, invasion, pigment production, and mitotic activity. It is believed that pigment production is no criterion of malignancy for pigmented and non-pigmented tumors are equally malignant, and, in fact, non-pigmented melanomas may be even more malignant than a heavily pigmented tumor. Of course, the melanogen is present, but has not been oxidized to visible melanin which in itself may be evidence of less differentiation and of a more embryonal character of the tumor as a whole. Much of the same can be said for mitoses. While many of these tumors show considerable or even a very marked mitotic activity, the scarcity of mitoses in stained sections does not indicate any lessening of the inherent malignancy, a somewhat different finding from other malignant tumors. Cell type and cell arrangement seem to have little bearing on malignancy or prognosis. Definite melanoma is fully malignant regardless of the structure,

but it would appear from the study of this series that those tumors in which giant cells of tumor type are present seem to run a longer course, and it may yet be found that the prognosis, although serious, may be a little better in those cases in which the giant cells predominate or are present in appreciable numbers. Perhaps there may be some comparison to the juvenile melanoma described by Spitz⁸ which, while histologically malignant, shows many giant cells, and in a prepubertal patient frequently runs a favorable course, whereas the same tumor in an adult would be cause for great concern.

The superficial location and histologic lack of invasion seem to be favorable findings regardless of cell type. Great care has been exercised in attempting to determine this invasive feature or lack of invasion, and while it has not always proved to be of value with some of the patients in this series, it has been possible in certain ones to predict a good prognosis.

Microscopic invasion of blood vessels immeditaely suggests a hopeless prognosis with pulmonary metastases already established or soon to follow. On the other hand, metastases by lymphatics even with relatively massive involvement of regional nodes is not always such a disheartening finding, for radical surgery of the primary tumor and involved nodes may bring about favorable results in some instances.

A considerable amount of literature has accumulated relative to the best methods of treatment for melanoma. All agree that the treatment of choice in melanoma is a wide excision and skin graft, the excision including the subcutaneous tissue and fascia overlying the muscle. It has been the policy in the Winship Clinic to do a wide excision and skin graft first, followed by a regional lymph node dissection when metastases were suspected. In the future we plan to do prophylactic regional node dissections

more frequently, because over 90 per cent of the 5-year cases developed metastases; 72 per cent of these had regional metastases before generalized disease became evident. Relatively few developed skin nodules between the primary site and the regional nodes. Those that did had the nodules scattered over a wide area rather than in a line representing the course of the lymphatics. For this reason, we question the wisdom of dissection in continuity unless the primary lesion is within a few centimeters of the regional nodes. An argument against radical amputation, which is recommended by some, is the fact that 28 per cent of our patients with melanoma developed distant metastases before or coincident with regional involvement.

The experience in the Winship Clinic with radiation treatment for melanoma indicates that there are isolated cases where radiation has some beneficial effect on metastases. In general, however, radiation is not recommended as a routine treatment for melanomas.

The diagnosis of melanoma is based upon the changes which occur in a new lesion or a previously existing pigmented area on the skin. Change in color with the extension of dusky pseudopods, increase in size, and ulceration of lesions should be suspected. It might be of benefit to point out that not all pigmented lesions on the skin are melanomas. A number of pigmented lesions appear on the skin most often in the older age group and cause considerable confusion in the minds of physicians as to their true status. The most common of these lesions is the pigment forming basal cell carcinoma. Other pigmented lesions, as listed by Stewart and Bonser¹⁰, are pigment forming keratinizing squamous papilloma, pigment forming benign calcified epithelioma, and pigment forming squamous cell carcinoma and also pigmented keratoses. These lesions

may often closely resemble melanoma. In many cases, the final diagnosis is not complete until the lesion has been excised and microscopic sections carefully examined. Even then in borderline cases it may be difficult to determine whether the lesion is actually malignant or not.

The question of biopsy in melanoma is important. An intact tumor should not be incised by any means. If histologic examination is necessary for the diagnosis of a suspicious lesion, the entire tumor should be excised with the scalpel including a generous margin of normal skin and subcutaneous tissue. The cautery should not be used. On the other hand, if the lesion is already ulcerated, infected, and bleeding, it is probable that the trauma of a careful biopsy does no more harm than has already been done by the local injury to the tumor by irritation and infection already present. However, it is best to remove the entire lesion widely.

Summary and Conclusion

From a study of 129 proven cases of melanoma in the Winship Clinic, the following conclusions are deduced:

1. Male and female incidence of melanoma is equal.
2. Melanoma appears most commonly between the third and sixth decade. Prepubertal melanomas show the best prognosis.
3. Melanoma appears on the head and neck more frequently than in other areas of the body. Lower extremity is next, then upper extremity, eye and genitalia in consecutive order.
4. Cell type *per se* probably has no effect upon the prognosis of melanoma, although in this series the giant cell type showed some slight advantage in survival.

5. The small, superficial non-invading lesion shows the greatest survival rate and best prognosis.

6. Ulceration of the lesion at the first visit bears a direct relationship to prognosis since the survival rate with non-ulcerated lesions in this series is 50 per cent better than that of the ulcerated lesions.

7. Trauma is reported in 75 per cent of the cases but the untraumatized lesions show no better survival or prognosis.

8. The five-year survival rate for our patients with metastases at first visit is 4.3 per cent, without metastases at first visit 26.3 per cent. Total survival rate for the five year group is 14.6 per cent. In the three to four year group for patients with metastases at first visit, the survival rate is 12.5 per cent. In individuals without metastases at first visit, the survival rate is 63.6 per cent. The overall survival rate for the three to four year group is 50 per cent. Melanomas without metastases evident at the first visit show the best prognosis. The presence of metastases at the first visit is a poor prognostic sign although not hopeless. Most of the deaths from melanoma occurred within three years. A few patients had recurrence between five and ten years after treatment.

9. In relating body distribution to survival, it appears that lesions of the head and neck show a greater survival percentage than those of lesions in other locations.

10. Treatment recommended in melanoma is wide excision, including the subcutaneous tissue and underlying fascia, and skin graft to be followed by regional lymph node dissection in three to six weeks if there is no evidence of distant metastases.

11. Radiation of metastases is occasionally of palliative value but is not recommended as a routine procedure.

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DISCUSSION

DR. C. H. RICHARDSON, JR. (Macon): I am substituting for Dr. Richardson, Sr., with apologies.

The use of presacral sympathectomy in the treatment of intractable dysmenorrhea is a relatively new procedure, and there is not a great deal of experience to judge it by. However, reports from the Lahey Clinic and other good investigators, as well as this excellent paper by Dr. Evans, lead me to believe that it will be used a good deal in the future.

A recent case in which we have employed it in conjunction with a suspension has brought extremely gratifying results. As far as I know there are no contraindications to the operation, and often it can be combined easily with other conservative surgery.

Anyone who has been around the surgical clinic has seen a lot of chronic leg ulcers, and appreciates anything that anyone can do for those people. Dr. Wall is to be congratulated for his work along this line.

In my experience these ulcers are not simple. There is usually a multiplicity of factors. Each one must be carefully studied in order to treat them in any sort of effective way. However, fasciotomy by releasing the tension in the leg and increasing the blood supply has often been an adjunct to some other form of surgical therapy.

I have not used the exact procedure which Dr. Wall has used, but often a procedure is indicated which is well known to the plastic surgeons and not appreciated quite so much by the general surgeons, and that is a total excision of the scar tissue around these chronic ulcers, and the application of a fresh split thickness graft.

Of course, before this will work, relief of venostasis by ligation of all varicose veins is indicated. It is necessary to have a good vascularized bed on which to place the graft. I am impressed by this extra procedure of fasciotomy.

In discussing the paper on melanoma, I would like to mention a brief review which I have made in the last few days of the cases of melanoma that we have on record in the Macon Cancer Clinic. This goes back over the past twelve years. All I could find were twenty-two cases. Possibly there were more, but in approximately 5,000 patients who have attended this clinic we have had 22 proven melanomas.

As of this time, three of these are alive and well from two to five years; three others are recent and don't mean very much. There are several others that were lost to follow-up, but presumably are dead or have metastases. In other words, this is a very bad disease, and I think that has been the experience of all who have reported it.

During these twelve years our feeling about the treatment has changed somewhat. Originally we believed in wide local excision. Now we combine this with node dissection. I don't believe that at any time it is a very good thing to biopsy them if we suspect their nature.

It is interesting that of the three cases who are alive and well, all had only wide local excision of the lesion. All the other cases that had more radical surgery have now died or had metastases, as I mentioned before. That was not because of their radical surgery, but because they were bad cases, recurrent cases, cases that had been treated with paste or some other form of inadequate

treatment. It is our impression that when a melanoma recurs it is almost incurable.

We had eight cases of head and neck, four trunk, and ten of the lower extremity. Ten were females and twelve were males. Those that had satellite nodules rapidly failed, no matter what the treatment was.

We have not employed x-ray therapy at all, although some of these have had radium locally. Two of the cases that are alive and well had radium or local excision plus radium to the local lesion.

It is our impression that the far-advanced cases seem to go downhill faster and have recurrences faster after surgery. I would like to hear if Dr. Trichner has had any experience along this line. It would almost seem that the tumor is not curable if it is not in an early stage, and when there are palpable hard lymph nodes in the regional distribution, I think it is a very advanced stage, actually.

It may be better, then, to leave them alone, if node metastases are present and to do nothing, because none of our cases has been cured or even benefited by the operation.

Perhaps Dr. Brown will comment on this.

CHLOROMYCETIN IN INFECTIOUS MONONUCLEOSIS

RUFUS F. PAYNE, M.D.

and

FRED CRENSHAW, M.D.

Rome

Lewis¹ has reported treating a child with chloromycetin after penicillin and aureomycin had failed to influence the course of infectious mononucleosis. Although not treated until the 14th day, the case appeared to respond immediately but relapsed and it was thought that relapse was due to the fact that the drug was given for only three days. There was also immediate response the second time the drug was given and there was no relapse after the completion of a week's treatment.

Hirsch² also reported treating an adult whose onset had been eight months previously but who continued to have subjective symptoms in addition to persistence of the typical cells in the blood smear and the presence of generalized "shotty" lymphadenopathy. This case also showed response to chloromycetin with disappearance of the adenopathy and a return to normal in the blood picture.

We wish to report a third and different type of case which also showed dramatic response to the drug:

CASE REPORT

J. C., white, male, aged 15, became ill on July 5, at 11:00 p.m., with chill. He had not been ill previously. Temperature was not taken that night but on the following day he consulted us and at that time his temperature was 102 F. He was asymptomatic except for malaise and there were no significant physical findings noted. Specimens of blood and urine were collected and he was sent home and put to bed. He was seen again the following day and at this time several small nodes were palpable in the cervical chain, bilaterally; there was slight redness in the throat and a questionably enlarged spleen. Temperature had not dropped below 102 F. and there was an increase in malaise but patient was not prostrated and, in general, had no complaints. Pulse rate was only 80

at a temperature of 102 and there was some slight nausea, and the patient was constipated. He also complained of being cold frequently but frank chills were absent.

Laboratory findings at this time shows urinalysis normal. R.B.C. 5.5, Hbg. 16 Gm., W.B.C. 2,700 with 50 segs, 45 lymps, 4 monos, and 1 eosinophile. At this time we thought that typhoid or infectious mononucleosis was the most likely diagnosis as the other likely diseases were ruled out by history or physical findings. The patient had never been inoculated against typhoid and gave a history of having been swimming in waters which are probably contaminated with raw sewage. Blood was collected for culture, heterophile, and further counts, and the patient was started on chloromycetin in a dosage of one gram every six hours.

Twelve hours later temperature was normal and was not elevated higher than 99 thereafter. At this time dysphagia became noticeable and the pharyngitis became more noticeable on physical examination. Spleen was never palpable again; there was no liver enlargement and no generalized adenopathy. Chloromycetin was continued for one week on the following schedule for the course: (Weight, 120 lbs.)

Day	Dose	Frequency	Total per 24 hours
1	1 Gm.	6 hour intervals	4 Grams
2	"	"	4 "
3	3/4 "	"	3 "
4	"	"	3 "
5	1/2 "	"	2 "
6	1/2 "	"	2 "
7	1/2 "	"	2 "

There were no side effects noted from the drug and the patient was kept on a soft diet and appeared to enjoy his food throughout the course of treatment.

White Count and Differential

Date	Total W.B.C.	Polys	Lymphs	Monos.	Eosin.
7/6	2,700	50	45	4	1
7/7	2,300	75	24	1	
7/9	2,400	36	53	11	
7/11	4,300	18	79	2	
7/13	3,900	43	55	1	1
7/15	6,600	43	37	17	3
7/20	6,000	37	60	3	
9/14	7,550	45	55		

Heterophile Antibody Titers

Date	Titer
7/7	1:32
7/11	1:64
7/15	1:128
7/20	1:256
9/20	1:64

Discussion

There appears to be no reasonable doubt that this was a case of infectious mononucleosis since the typical cells were present in the smears and have been seen and confirmed by several hematologists. It is quite interesting to note that there was never a marked rise in total white count and the effect of the drug in this respect is problematical. As the patient was a visitor at the time he became ill it was not possible to get counts after July 20, except for the count obtained on September 14. It is possible that the count did rise to a higher level. The dramatic response of the patient is indicative that the drug exerted a specific action and the fact that there have been no further symptoms is reasonable evidence that the dosage employed is adequate.

Summary

An additional case of infectious mononucleosis showing marked response to chloromycetin is presented to substantiate the opinion of other observers that the drug exerts specific action in this condition.

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THE PRESENT STATUS OF THE MANAGEMENT OF THE Rh NEGATIVE PREGNANT WOMAN

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Surg. Clin. North America, 1950, 30:169

In the white population of America, the chances of an Rh negative woman being married to an Rh positive man are six out of seven. There are several ways in which an Rh negative woman may be sensitized to Rh positive blood. She may be transfused with Rh positive blood. Curettage of an incomplete abortion of an Rh positive pregnancy may scrape sufficient fetal blood cells into the uterine vessels to cause sensitization. Manual removal of the placenta at term, or cesarean section in an anteriorly placed placenta might have a similar effect.

Roughly speaking, the general overall incidence of hemolytic anemia approximates one case in 300 deliveries. Not more than one in 20 Rh negative women married to Rh positive husbands give birth to infants with hemolytic anemia in any pregnancy.

In an Rh negative woman, pregnant for the first time, not having been previously sensitized, the outlook for the child is fairly good. The outlook for future children may be estimated, to some extent, by the reaction of the mother to her first pregnancy. Estimates of antibody titer, if repeated every month, will give a clue. Blocking antibodies seem to be of more serious import than those of other types.

An Rh negative woman, once sensitized, remains so sensitized forever. Her outlook for subsequent normal children depends upon whether her husband is homozygous or heterozygous. Accurate determination of this condition in the husband depends upon the Rh status of his parents. If both are Rh positive and his first born is Rh positive, he is undoubtedly homozygous and it can be expected that all the rest of the children, resulting from his marriage to an Rh negative wife, will be Rh positive. If one of his parents is Rh negative, he is heterozygous and the expectancy of an Rh negative child to his marriage is variously estimated at from 28 to 40 per cent. Therefore, a woman bearing a normal Rh positive

firstborn followed by a second born dying of hemolytic anemia, could be assured of better than a 50-50 chance of a living third child, if her husband can be shown to be heterozygous. However, if the husband proves to be homozygous, and the second baby was a victim of hemolytic anemia, all the rest of the children from this marriage will suffer the same fate.

Theoretically, purified and free haptenes would combine with the antibodies in the mother's system. However, such haptenes have not yet been produced. Clinically, the obstetrician must anticipate the possibility of hemolytic jaundice and be ready to treat it. If this is the patient's first pregnancy, the outlook for the child is good. If this is the second pregnancy, monthly antibody determinations from the fourth month on should be done. If none develop, the outlook is good and will probably remain so for future pregnancies. If the antibody titer rises sharply during the last two months of pregnancy, should early termination be considered? The known hazards of prematurity more than offset the benefits of removing the fetus from an environment whose dangers are not accurately predicted.

If the birth of an infant with hemolytic anemia is expected, preparation should be made for treatment. Immediately upon delivery, a smear of the cord blood may show a high percentage of nucleated red cells. A palpable spleen is another significant finding. Jaundice and petechiae are serious. The best treatment is to introduce Rh negative blood of the same group as the baby's. A second principle is to prevent additional blood entering the baby's body from the placental circulation. Accordingly, the cord should be promptly cut and tied. The umbilical vein may be used for exchange transfusion if such is to be done within eight to 10 hours postpartum. After this time, dangerous thrombosis may develop.

If the baby at birth does not present signs of hemolytic anemia, the cord should be clamped immediately. In the milder forms of the disease, a red blood cell count of over three million should be maintained. This can be accomplished by multiple small transfusions. Various additional hemopoietic measures may be used. These babies should not be breast fed, since Rh antibodies occur in the mother's milk.

Damage to the liver, kernicterus, and discoloration of the deciduous teeth are among the commoner complications. However, the outlook for a normal child in later years is by no means hopeless if hemolytic disease is treated promptly.

TREATMENT OF ACRODYNIA WITH BAL

Summary of Paper

Read before the International Congress of Pediatrics, Zurich, Switzerland, July, 1950.

Based on the finding of mercury in the urines of several patients with Acrodynia by Warkany and Hub-

bard, it seemed logical to try BAL (2, 3-dimercaptopropanol) as a specific therapeutic agent to eliminate the mercury. The reaction to mercury is not that of a gross poisoning but a sensitization to the ingestion and storing of small amounts of the metal. Excretion and desensitization proceed spontaneously over long periods of time in untreated cases, and it was the presence of small amounts of mercury in the urines being slowly excreted which led Warkany to the discovery of mercury as an etiological factor in the disease.

Through the cooperation of many of my colleagues, some in foreign lands, it has been possible to collect reports on 51 cases of acrodynia treated with BAL. 45 of these have had proven mercury in their urines. Results of treatment were as follows:

- 29 recovered rapidly.
- 12 recovered gradually.
- 6 recovered slowly.
- 1 failed to respond.
- 3 deaths (none due to BAL).

Analysis shows that those who received BAL therapy promptly showed response while those receiving it late had a high percentage of failures.

Dosage was 3 mg/kg of a ten per cent solution of BAL in peanut oil—every four hours for twelve doses—every six hours for six doses—every twelve hours for fourteen doses.

Because of the large number of different observers it is difficult to evaluate the results of treatment. Increased rate of excretion of mercury has been shown in some cases and the general favorable outcome of most cases would seem to indicate its usefulness.

Woody and Kotemani have shown that if the dosage is increased much above the 3 mg/kg level that reactions will occur but in some instances it may be justifiable to do so and Weech has told me of a case who recovered after several times the usual dosage.

The sources of mercury in our cases has usually been teething powders but some from mercury ointments and calomel.

Reports from the literature show the disease to be most prevalent in Australia, England, Scotland and Switzerland, all areas in which teething powders and calomel are extensively used. Southby recently reports 300 cases with 33 deaths. The age incidence of all was within the teething period. Cheek and his co-workers have recently advanced a thesis that the clinical syndrome of acrodynia is due to a disturbance of the adrenal gland with a depletion of body sodium and it seems possible that the mechanism of symptomatology may come about in that way.

It would seem reasonable to eliminate mercury from teething powders and other useless forms of medication but since the disease is relatively rare a judicious use of mercury would not seem contraindicated on the basis of possible acrodynia.

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COMMITTEE ON CONSTITUTION AND BY-LAWS

Second Meeting

The second meeting of the Committee on Constitution and By-Laws will be held at the Capital City Club in Atlanta on March the 7th at 6:30 P. M. Members of the Association are cordially invited to present their views and suggestions to the Committee either in person or by letter.

The first meeting of the Committee was held in Macon on January the 10th, notices of which appeared in the November and December issues of The Journal.

ALLEN H. BUNCE, Atlanta, Chairman
C. H. RICHARDSON, SR., Macon
MARION C. PRUITT, Atlanta
W. F. REAVIS, Waycross
JOHN A. DUNAWAY, Atlanta, Attorney for the Assn.
A. M. PHILLIPS, Macon, President
EDGAR D. SHANKS, Atlanta, Secretary-Treasurer.

THE JOURNAL

OF THE
MEDICAL ASSOCIATION OF GEORGIA

EDGAR D. SHANKS, M.D., Editor
478 Peachtree Street, N. E., Atlanta, Ga.

FEBRUARY, 1951

MEDICAL PREPAREDNESS FOR WAR

In the extensive discussion today of preparedness for possible war, the medical profession can say that it is always prepared for war. The first day the medical student begins his studies, in learning to diagnose and treat diseases and injuries, he is starting to prepare for war. In the brief peaceful period in our country, between 1898 and 1917, no one thought we would ever again be engaged in military conflict. We were studying and practicing medicine with the false feeling that war was a thing of the past. Then came the rude awakening when we found that many of us must leave our homes and transfer our knowledge and ability to care for soldiers on the battlefields and in army hospitals in foreign lands. Since then there has been but little rest from war and rumors of war, and the end is not in sight.

Great preparations are necessary, and high expense involved, in mobilizing and training armies, stabilizing industry, fixing price controls in food and wages, and making ready for defense. This takes time, but medicine is ready today. The rules and customs of the medical corps have to be learned, but the principal part of the doctor's assignment has already been mastered: the prevention and relief of sickness and trauma. And not only do the youngest men respond, but also the brightest stars and specialists of the profession, and all go willingly.

While individual doctors have friends and patients who place them among the men whom they love and esteem first, in recent years the profession has come under sharp criticism and condemnation by uninformed persons, for various causes, chief of which is our opposition to socialized medicine. When such persons view the ready way in which so many physicians and surgeons answer the call of the country, they must modify or dismiss their unjust charges. What other groups of citizens are considered so essential to defend the country as to be required to register when the possibility of war is so uncertain as it is today?

If there is any compensation for war, so far as medicine is concerned, it might be the increased knowledge gained in handling patients in such large numbers and under conditions which enable them to be studied continuously over long periods of time. By such means in World

War II the value of the sulfa drugs, antibiotics and other agents was learned in much less time than would be required in civilian practice. And so from the night when Ambroise Paré ceased pouring boiling oil into wounds each war has taught more about the care of the sick and wounded.

The application of the lessons accumulated in warfare has saved lives through the centuries, down to the present time. Brigadier General Hugh Morgan is authority for these comparative figures, published in "Doctors At War," edited by Morris Fishbein:

	World War I	World War II
Death rate in wounded.....	8.1%	3.3%
Meningitis mortality	38.0%	4.0%
Pneumonia mortality	28.0%	0.7%
Dysentery mortality	1.6%	0.05%
Annual death rate per 1,000 for all diseases of the Army, excluding surgical conditions	15.6%	0.6%

If the present dangerous condition of world's affairs leads to another world conflict, may the results even surpass this remarkable record.

In activating hospitals and personnel for service it is hoped that the War Department profits by recent experiences and endeavors to avoid long periods of idleness in camp for doctors whose services are ill-spared from home. In a statement issued by the American College of Surgeons, written by Dr. Evarts A. Graham, two important suggestions are made: (1) that military hospitals be located near centers of population where civilian doctors may relieve medical officers assigned to duty with the armed forces, and (2) Utilization of Veterans Administration facilities for the care of those patients whose condition is such as to preclude eventual return to military duty.

May none of our preparations for war prove to be necessary, but the axiom still holds that the surest way to prevent war is to be ready for it.

FRANK K. BOLAND, M.D.

PLANS ANNOUNCED FOR RAISING FUNDS FOR MEDICAL SCHOOLS

Announcement was made January 19 of the formation of the American Medical Education Foundation, a not-for-profit corporation under Illinois laws, to raise funds from the medical profession to aid medical schools.

The fund, initiated by a contribution of a half-million dollars voted by the Board of Trustees of the American Medical Association in December, has been widely acclaimed as one of the most constructive programs ever undertaken by the A.M.A.

"The medical schools of the United States stand in need of additional financial support if they are to continue to provide the American people with physicians second to none in the quality of their education and training," said Dr. Elmer L.

Henderson of Louisville, president of the A.M.A.

"Since the tremendous advances in the health of the American people in the last 50 years have been due in large measure to the great improvements in medical education during the same period, it is clear that inspiring adequate financial support of our medical schools is vital to the present and future health of the nation."

In announcing the formation of the foundation, the January 20 *Journal of the A.M.A.* urged the doctors of the nation to contribute promptly and generously.

"It is planned that the foundation will coordinate its activities closely with other major efforts to raise funds for medical education from voluntary sources which it is hoped will be announced shortly," said the *Journal*.

"Because of rising costs, inflation, fewer large individual benefactions and reduced income from endowments, the medical schools need, without further delay, assistance of the type this fund can give.

"It is the desire of the foundation that the first annual disbursement of funds to the medical schools be made this spring. It is clear that if the foundation's contribution is to be an effective one, a substantial fund must be raised by the medical profession within the next few months."

The *Journal* further pointed out that almost every physician now practicing received his medical education for less than what it cost his medical school. It added that many physicians have discharged this debt to society in full or in part by public and charitable activities and by donations to the schools with which they have been associated, but continued:

"The medical profession has traditionally accepted a large measure of responsibility for the training of the continuing flow of young physicians, on which it must depend for recruits and replacements in its efforts to serve humanity.

"It is to be expected, therefore, that all physicians regardless of the other contributions they have made to society, will want to share in the responsibility of making the foundation a success.

"The American Medical Association has indicated its belief that the possibilities of securing adequate support for medical education from voluntary sources are far from exhausted."

Besides Dr. Henderson, the foundation's board is composed of the following:

From the A.M.A. Board of Trustees: Dr. Louis H. Bauer, Hempstead, N. Y., chairman; Dr. Gunnar Gundersen, LaCrosse, Wis.; Dr. Edwin S. Hamilton, Kankakee, Ill., and Dr. Walter B. Martin, Norfolk, Va.

From the A.M.A. Council on Medical Education and Hospitals: Dr. H. G. Weiskotten, Syracuse, chairman; Dr. Donald G. Anderson, Chicago, secretary; Dr. Victor Johnson, Rochester, Minn., and Dr. Harvey B. Stone, Baltimore.

Dr. George F. Lull, Chicago, secretary and general manager of the A.M.A., and Dr. J. J. Moore, Chicago, treasurer.

REPORT ORAL USE OF CORTISONE EFFECTIVE IN RHEUMATOID ARTHRITIS

Two Los Angeles physicians report that cortisone given by mouth is just as effective as intramuscular injections of the drug in the treatment of rheumatoid arthritis and, in addition, has distinct advantages.

Writing in the January 6 *Journal of the American Medical Association*, Drs. Edward W. Boland and Nathan E. Headley, specialists in internal medicine, describe their observations of 23 patients who were given oral preparations of cortisone. For control purposes, 14 were selected because they had previously received intramuscular injections of the drug.

In 22 of the 23 patients, they found oral preparations were "highly effective" in suppressing the activity of the disease or maintaining control of the rheumatic manifestations, or both. They added:

"The pattern of improvement with initial large suppressive doses of cortisone given by mouth was similar to that observed in patients who have received equivalent amounts of the hormone by intramuscular injection."

It was suggested, however, that doses of one-fifth to one-third more may be necessary if the drug is given orally.

They found, in general, that while beneficial effects were produced more rapidly with oral use of the drug, these benefits also disappeared more quickly. These observations were further supported by the fact that results were "definitely best" when the drug was taken in divided doses throughout the day instead of in one large dose.

Effects of the drug were noted in from 5 to 48 hours when given orally. This is in contrast to the 48 to 72 hours usually required with intramuscular injections.

The oral use of cortisone in treatment of chronic diseases such as rheumatoid arthritis has distinct advantages, the doctors pointed out. The main arguments for oral use are: discomfort from repeated intramuscular injections is eliminated, the patient is made independent of others for his medicine, the stimulation of mental activity and appetite is less pronounced and it is less expensive.

The most serious objection to the use of cortisone for chronic rheumatoid arthritis, they said, "is the high incidence of hormonal side effects when administration is continued (and it must be continued for effects are temporary and not curative), especially in large doses, for extended periods."

Adverse reactions were found to be substantially reduced by using smaller doses for prolonged control or by the employment of inter-

rupted schedules of treatment rather than large continuous doses.

For doctors and laymen alike, Drs. Boland and Headley cautioned:

"Many more facts must be ascertained before this powerful hormone with its many physiological actions can be considered as a safe therapeutic agent for general distribution and use."

RADIOACTIVE DYE USED TO DETECT BRAIN TUMORS

A high degree of accuracy in detecting and localizing brain and spinal cord tumors by using a radioactive dye is reported by a group of Chicago medical researchers after a study of 200 suspected patients.

A 95.5 per cent accuracy in diagnosis of tumors of the central nervous system is revealed in the December 23 *Journal of the American Medical Association*. The report was made by Drs. Loyal Davis, John Martin, Moses Ashkenazy and George V. LeRoy, and Theodore Fields, B.S. All are associated with the Department of Surgery, Northwestern University Medical School and Hines Veterans Administration Hospital radioisotope unit, Chicago.

The study was begun in July, 1949, and is still being carried on. Since the initial report citing 200 patients was submitted to the *Journal*, hundreds more have been examined. Dr. Davis estimated that approximately 500 patients now have been studied and diagnosis made "with the same degree of accuracy."

The radioactive substance used is called diiodofluorescein—a chemical iodine dye compound. It is furnished by the Isotope Division, Oak Ridge National Laboratory, United States Atomic Energy Commission, to commercial pharmaceutical laboratories for preparation of the final product used in the examinations.

This radioactive dye has an affinity for tumor tissue, the surgeons said, reporting that "the more malignant the neoplasm the greater the radiofluorescent concentration." By using radiation detection equipment the concentration is located, revealing the site of the tumor.

Dr. Davis credits Dr. G. E. Moore, Minneapolis, with first conceiving this method of tumor detection but "it was first put to practical use in our study," he explained.

Briefly, this is what happens when a suspected tumor patient is examined by means of this radiodye:

The substance is injected into a vein—usually in the arm—in an exceedingly minute quantity.

"The quantity is so small," Dr. Davis says, "that there is no danger of radioactivity to the patient and the dye is quickly excreted from the body."

Within a minute or two after the injection, the radioactivity at the surface of the head is at a maximum. This decreases rapidly over the next 10 to 30 minutes when it tends to

level off. After the leveling off interval and for the next 1 to 2 hours, the decline in counts is gradual.

Radioactive radiations are measured by means of special detection equipment. A tube—called a Geiger-Mueller tube—is placed directly on the scalp. This tube sends radiations to a meter and the "count" or "clicks" per minute are recorded on a graph.

Symmetric positions can be studied accurately at this time. The most significant counting rates take place within 1/2 to 2 hours after administration of the radiodye.

Thirty-two different positions on the scalp are surveyed with the Geiger-Mueller tube including 13 areas symmetrically studied on each side of the skull, alternating from left to right, and 6 middle positions. In this manner every inch of the skull is examined.

Suspected areas are rechecked several times to insure a high degree of accuracy. In order to determine definitely the site of the tumor, comparisons are made with the corresponding position on the opposite side of the head and positions surrounding the suspicious area.

In the normal person, the counts made over symmetric sites on the head vary from 0 to 40 counts per minute. Variations of more than 10 to 15 per cent from this norm are considered significant. The over-all increase of radioactivity over a tumor itself may be 50 to 100 per cent greater than the count over the same site in a normal brain.

"Use of this method of comparison with the normal values, and with symmetric and adjacent area values for a specific time interval," Dr. Davis explained, "has improved the reliability of our results."

Statistically a breakdown of the results of this test and further surgical verification on the initial 200 patients studied looks something like this:

Proved tumors were noted in 110 instances. The radioactive isotope tracer test accurately diagnosed 101 of this number, or 92 per cent.

"This exceeds by far the accuracy of any other single neurosurgical test or procedure," pointed out Dr. Davis, "particularly with regard to localization."

Eighteen patients, at the time of the report, were suspected of having tumors which had not been verified by operation.

Seventy-two of the 200 were believed to be tumor free as a result of the radiodye test. These diagnoses proved to be 95 per cent accurate.

Most of the errors were due to cystic tumors which are made up of liquid for the most part instead of tissue. The radioactive material is attracted only to actively growing tumor tissue. In many cystic tumors the amount of actual tumor tissue is too small to attract any noticeable quantity of radioactive substance and no suspicious counts are recorded.

In order to determine the comparative accuracy of the radiodye method with other studies used to detect brain tumors, electroencephalography and pneumography studies were made.

Electroencephalography is a graphic recording of electrical currents of the brain. Pneumography is a method of localizing a tumor by injecting air into the ventricles of the brain and studying the results by means of an x-ray picture.

Electroencephalographic studies were performed on 110 of the 200 patients. In this number there were 36 incorrect diagnoses. Radiodye studies performed on the same 36 patients permitted accurate diagnosis.

Pneumographic studies were performed on 121 proved tumor patients. Results of this method of examination suggested no tumor in 8 of the patients. On the other hand radiodye testing accurately located a tumor in all but one of them.

"Localization by the radiodye method proved to be much more precise than with electroencephalography or pneumography whenever verification was obtained at surgery or at autopsy," said Dr. Davis, pointing out that pneumography was 63 per cent focally accurate and electroencephalography was only 45 per cent focally accurate.

A typical example illustrating the importance of the development of the radiodye method of examination is shown in the case of a 46 year old man—a shopkeeper—who complained of severe headaches and dizziness for over a period of one year. In addition, he told of difficulty in walking. Symptoms and examinations during this period were inconclusive and unsatisfactory. With the use of the radiodye method the tumor was located with great accuracy and treatment given the patient.

Modifications of this case were repeated over and over, Dr. Davis said.

Not only does the radiodye indicate a greater degree of accuracy, but according to the report, it is relatively harmless and simple. On the other hand, pneumography produces severe headaches and occasional shock and, on the whole, is an exceedingly discomforting procedure as far as the patient is concerned, the surgeons pointed out.

In summary of the importance of this new method and its over-all evaluation, Dr. Davis said:

"Limitations of the test have proved to be few provided due regard is made to accurate, consistent placement of the Geiger tube on the skull and proved suspicious areas are rechecked and compared to symmetric and adjacent areas of the skull.

"It must be remembered," Dr. Davis emphasized, "that this is but one of a number of diagnostic tests used to detect brain tumors. A

combination of the studies should be made and information correlated. It is true, however, that we are depending more and more on the radiodye method.

"Furthermore, the test is not a simple one but requires the expert interpretation and judgment of a doctor trained in neurology.

"The goal for which we are now working involves a modification of the Geiger-Mueller tube for use during actual operations. Tumor tissue often blends in so well with brain matter that its size and shape cannot be seen even with the aid of a microscope. The development of a small surgical instrument capable of picking up radioactive radiations would permit the surgeon, in effect, to hear the boundaries of the tumor even though he cannot see them. More complete and accurate removal of tumor tissue would then be accomplished."

NERVE SURGERY BRINGS RELIEF TO ANGINA PECTORIS SUFFERERS

Surgical removal of sympathetic nerve tissue near the heart has brought relief to patients suffering from chest pains due to an abnormal state of the heart arteries, according to three Boston physicians.

This condition—known as angina pectoris—produces pain in the chest over the upper part of the heart radiating in various directions but mainly into the left neck and down the left arm. It is common in persons with high blood pressure.

According to a report by Drs. James A. Evans, James L. Poppen and James B. Tobias in the December 23 *Journal of the American Medical Association*, sympathectomy—as the operation is called—was performed on 10 high blood pressure patients suffering with severe attacks of disabling angina pectoris with "satisfactory results" in all cases.

Complete relief was found in half of the patients, of whom three reported throat constriction sensations, a residual symptom in this operation. The remaining five patients experienced "satisfactory results" rather than complete relief. Results were studied over a period of from three months to three years.

The doctors are associated with the Lahey Clinic, Boston. Dr. Evans is with the Department of Internal Medicine, Dr. Poppen is with the Department of Neurosurgery and Dr. Tobias is a fellow in internal medicine.

INDUSTRIAL HEALTH CONGRESS IS EXTENDED TO THREE DAYS

Because of the importance of the subject, the originally announced two-day eleventh annual Congress on Industrial Health has been extended to three full days.

Announcement to that effect was made by Dr. Carl M. Peterson of Chicago, secretary of the

Council on Industrial Health of the American Medical Association. The meeting will be held in the hotel Atlanta Biltmore, Atlanta, February 26-28. It will be sponsored by the council in cooperation with the Medical Association of Georgia and the Fulton County (Georgia) Medical Society.

This will be the first meeting of its kind on a national scale to be held in the South. Dr. Peterson pointed out. It is a recognition of the industrial importance of that section of the nation, he said. How the South is meeting the health problems of workers will be discussed in a panel which will bring together medical leaders from that part of the country.

The importance of the health of workers in a state of national emergency will be told by Dr. Elmer L. Henderson of Louisville, president of the A.M.A. The role of the handicapped in time of emergency will be stressed by Dr. James E. Paullin of Atlanta, a past president of the A.M.A.

Other topics to be considered by the congress include the effect of poisons used in agriculture and industry; hand injuries; the worker with a heart ailment; the physician in industry; lung diseases as a result of dust, and the effect of noise in industry.

CONFERENCE TO CONSIDER WARTIME MEDICAL PROBLEMS

The problems arising from the mobilization of medical manpower was the chief topic at the forty-seventh annual Congress on Medical Education and Licensure held in Chicago February 11-13.

The congress was sponsored jointly by the Council on Medical Education and Hospitals of the American Medical Association, the Advisory Board for Medical Specialties and the Federation of State Medical Boards of the United States.

Officials of Selective Service, the Armed Forces and other governmental agencies met with medical school authorities at the session on Monday morning, February 12. Dr. H. G. Weiskotten of Syracuse, N. Y., chairman of the A.M.A. Council on Medical Education and Hospitals, presided.

"Medicine, Mobilization and Manpower" was discussed by Dr. Howard A. Rusk of New York. Dr. Rusk is chairman of the Health Resources Advisory Committee to the National Security Resources Board and the National Advisory Committee on the Selection of Doctors, Dentists and Allied Specialists to the Selective Service System.

Classification policies of Selective Service was outlined by Col. Richard H. Eanes of Washington, its chief medical officer. Dr. Stanley W. Olson of Chicago, dean of the University of Illinois College of Medicine, made a report on a recommended curriculum in medical schools during a national emergency.

These three speakers also participated in a panel discussion of mobilization problems. The moderator was Dr. Donald G. Anderson of Chicago, secretary of the Council on Medical Education and Hospitals of the American Medical Association.

Other government participants in the panel were: Dr. Richard L. Meiling, director of medical services, Office of Secretary of Defense; Brig. Gen. Paul R. Robinson, chief of the personnel division, Office of the Surgeon General (Army); Brig. Gen. Dan. C. Ogle, deputy surgeon general (Air Force); Rear Adm. A. H. Dearing, assistant chief of the Bureau of Personnel and Professional Operations, Navy Bureau of Medicine and Surgery; Dr. W. Palmer Dearing, deputy surgeon general (Public Health Service), and Dr. E. H. Cushing, assistant medical director for research and education, Veterans Administration. All are of Washington.

Other participants were: Dr. Harold Diehl of Minneapolis, dean of the University of Minnesota Medical School; Dr. Stockton Kimball of Buffalo, chairman of the Joint Committee on Medical Education in Time of National Emergency, and Dr. Victor Johnson of Rochester, Minn., director of the Mayo Foundation for Medical Education and Research.

The congress also took up other phases of medical education and licensure.

HEALTHGRAMS

The great physicians of all time have understood that medicine is not a study of disease, but a study of man: an individual who is a member of a family and who is part of a community. . . . The purpose of medicine is to make available to all the people, in the greatest possible degree, the achievements of science as they relate to the promotion of health and to the prevention and treatment of disease. W. G. Smilie, M.D., *New England J. Med.*, January 12, 1950.

* * *

Health education and sanatorium treatment are our two greatest weapons in fighting tuberculosis. We must remember that each patient with active tuberculosis presents a medical problem, a social and welfare problem, an economic problem and, let us never forget, a public health problem. R. D. Thompson, M.D., *Bull. Nat. Tuber. A.*, Jan., 1950.

The Medical Association of Georgia will hold its next annual session at the Bon Air Hotel, Augusta, April 17-20, 1951.

NOTICE

An invitation is extended to the physicians and various institutions in Georgia to exhibit their work at the forthcoming meeting of the Medical Association of Georgia in Augusta, April 17-20. Applications for space should be sent to Robert B. Greenblatt, M.D., Chairman, Scientific Exhibits, Medical College of Georgia, Augusta. Deadline for receipt of applications is March 15th.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

FIRST YEAR'S EXPERIENCE WITH THE STATE PREMARITAL LAW

The Georgia premarital law became effective August 25, 1949. Intended primarily to prevent the spread of syphilis in the marriage relationship, it requires that the applicant for a marriage license have a blood test made by an approved laboratory and such physical examination as may satisfy the physician that the applicant is not infested with syphilis, or if so infected, that the disease is not in a communicable stage. The law is administered jointly by the State Department of Health and the Ordinaries of the several counties.

The law itself approves the laboratories of all other State Health Departments, the Army, Navy, and U. S. Public Health Service, and laboratories approved by these agencies. It specifies that all civilian laboratories within the State examining premarital blood specimens must be approved by the State Department of Health. It further provides that the tests employed shall be procedures approved by this department.

It became necessary for the State Department of Health to formulate some criterion by which these approvals could be made. Soon after this law went into effect a great many municipal, hospital, and private laboratories made application for approval under the provisions of this law. The test procedures recognized by the U. S. Public Health Service as acceptable were adopted by the State Department of Health as approved tests. These are Kahn, Kolmer, Kline, Eagle, Mazzini, Hinton, and V.D.R.L. tests.

The criterion for approval is based upon the inspection of the physical equipment, demonstration of performance of one of the above procedures by the technician, and the achievement of the requirements in sensitivity and specificity in a series of check specimens. Continuation of approval is made contingent upon participation in the serology evaluation study in which unknown specimens are distributed each month to all laboratories.

To date, 45 laboratories outside the State system have been approved under the provisions of the State Premarital Law. It may be said here that the 6 laboratories forming the State system are required to meet the same requirements in every respect as for all other laboratories. There were a few laboratories applying for approval which could not meet the requirements, and there are some which have recently made application and are now in the process of meeting the criterion.

There is no central registry of marriages within the State. The Ordinary of each county keeps his own records but is not required to make a report to a central agency. Heretofore, there has

been no means of ascertaining the number of marriages occurring in the State each year but now, by calculation from the reports from approved laboratories, a close approximation can be made.

During the calendar year of 1950 there were 92,328 premarital blood examinations made by approved laboratories. Since the State, County, and Municipal laboratories do not make any charge for this service, it is not surprising to find that of the total, 66,455 were made in these laboratories.

The results of examinations made in all of the approved laboratories are as follows:

Positive	4,128 (4.5%)
Doubtful	815
Negative	87,385

It may be pointed out that the law does not require negative serology and many of those applicants showing positive serologic reactions were certified by the physician if he was convinced that they had been given adequate treatment.

The state laboratories keep a record of the positive reactions by race and sex. Based on a total of 59,536 examinations these are as follows:

White male	155
White female	202
Colored male	1,291
Colored Female	1,534

This information is not available from the other approved laboratories but it is reasonable to assume that the same relationship exists.

There, of course, was some confusion at first among the applicants, physicians, and ordinaries, as to the requirements of this new law. The physicians and ordinaries were under the impression that they were to be supplied with premarital certificate forms to be given to the applicants. The State Department of Health, however, thought it better to supply these forms only to approved laboratories since they could not be executed until after the specimen of blood was examined. The certificate together with the report is then forwarded to the physician for his signature after which it is given by him to the applicant for presentation to the Ordinary at the time the application is made for a marriage license.

The serologic reports are confidential between the laboratory and the physician and they should be detached from the certificate and kept on file in the physician's office as a record of the examination. The certificate only should be given to the applicant. Some Ordinaries, however, misconstruing the law seem to insist on having the laboratory report attached to the certificate.

The State Department of Health has prepared a pocket size pamphlet in which a step by step procedure is given in securing a marriage license

in Georgia. These pamphlets have been supplied to all Ordinaries and will be furnished to physicians and applicants upon request. They should be very helpful in dispelling existing confusion in regard to the requirements of the law covering marriage.

The State Department of Health has also adopted a very simple means by which physicians can request premarital certificates to be issued on specimens of blood. Sheets of small perforated labels are supplied upon request. One of these labels attached to the serologic specimen identification form insures the issuance of a premarital certificate on that specimen. These labels also provide for the request of a premarital certificate for any other state, a supply of which is kept in the offices of the state laboratories. Some states, however, require that the certificate be signed by a physician licensed to practice in that state.

It appears through correspondence that some of the Ordinaries in the State feel that the premarital law is discouraging some of the negroes from securing marriage licenses, and are causing them to establish family life through the common marriage law. In some counties the Ordinaries report that they have sold fewer marriage licenses to negroes since the premarital law went into effect. The added expense for the premarital certificate may be responsible for some of this change in attitude at a time when more and more negroes were securing marriage licenses in order to have on record certifications required in establishing claims under provisions of governmental agencies.

It may be seen from the figures above as in other studies that the prevalence of syphilis is much higher among the negroes. If they should increasingly resort to the common law marriage, then this reversion defeats, in some measure, the purpose of the law to locate cases of syphilis and to treat it to prevent the further spread of the disease.

It is felt that the premarital law like all other laws through experience of its administration may require certain amendments. It has been found that the feature requiring that only the Georgia certificate form be accepted by the Ordinaries is inconvenient and cumbersome. The premarital laws in the 40 states passing such legislation agree in principle and purpose, even though no two of them are exactly alike.

It would appear that if an applicant satisfies the requirements of the premarital law in his home state then the certificate which would be acceptable in his state should also be acceptable in any other state having similar laws. The Georgia certificate form should also be accepted in other states. This, of course, brings up the question of reciprocity which, if insisted on, may be a hindrance in carrying out the general idea

of acceptance of the laboratory work and certification of physicians throughout the country in regard to the somewhat different premarital laws in the several states.

It is thought that the Georgia law should be amended so as to permit the Ordinaries to accept premarital certificates from any other state without requiring reciprocal agreement. It is believed that this attitude will ultimately prevail and that it will set a good example for the other states to follow.

A questionnaire to the Ordinaries suggesting this change brings out an almost unanimous approval of it. Such an amendment would lighten the burden of the administration of this law on both the Ordinaries and the State Health Department. Especially is this true now during the days of preparedness when the prospective groom, called to the service of his country, is located in some other state, and returns to his home state on short leave to be married.

There is also the question of a waiting period which is required by some of our neighboring states and which causes applicants from these states to come over into the border counties of Georgia for the marriage license and ceremony. This, of course, would be resisted by the beneficiaries in those counties. It is, more or less, a question involving moral and social problems, and does not directly relate to Public Health.

Some other amendments of minor importance correcting oversights in the initial legislation might also be helpful in the administration of the law.

E. L. WEBB

CYTOLOGICAL EXAMINATION REVEALS EARLY UTERINE CANCERS

Microscopic studies of smears taken directly from the uterine cervix and cervical canal are extremely useful in detecting early uterine cancer in women, according to two Cleveland physicians.

Drs. James W. Reagan and R. T. Schmidt, University Hospitals of Cleveland, report on the effectiveness of this so-called cytological technic in the January 13 *Journal of the American Medical Association*.

In a controlled series of tests, specimens taken from 108 proved uterine cancer patients were examined by this technic. Affirmative results were reported by Drs. Reagan and Schmidt in 103 of the 108 proved cases.

The accuracy and effectiveness of this method require a highly skilled microscopist trained in cell research. In addition much care must be taken in obtaining the specimen and in preparing the tissue spreads (or smears) for examination.

The report said:

"The cytological technic is useful in the identification of uterine neoplasms and may reveal the presence of lesions unrecognized with the use of endometrial curettage or cervical biopsy."

HEALTHGRAM

One of the most persistently discouraging facts about cancer of the lung, is the long interval of ten months that elapses, on the average, between the patient's first visit to the doctor and the time when the diagnosis is made. Overholt, R. H., and Schmidt, I. C., *New England J. Med.*, Nov., 1949.

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

AUXILIARY NEWS

BIBB COUNTY: There were nine new members when the Woman's Auxiliary to the Bibb County Medical Society held its membership Tea on October 10, 1950 at the Sidney Lanier House. Mrs. Lehman W. Williams was the honor guest and gave a most informative talk on the duties and responsibilities of officers and members of the Auxiliary.

Mrs. E. C. McMillan, co-chairman of the Prenatal Clinic, reports the Auxiliary having worked 214 hours on this project which the organization adopted as the medium through which it could best serve the community. Three Maternal Clinics are held each week from twelve o'clock to four and three Auxiliary members assist at each. For two years the Bibb County Auxiliary has served as an integral part of this program and will continue to do so this year.

Mrs. J. R. Shannon Mays, President-Elect of the Woman's Auxiliary to the Medical Association of Georgia, and Mrs. A. M. Phillips poured at the tea immediately following the meeting.

Members have given 346 hours to a total of 151 clinics for the Prenatal Clinic held by the Bibb County Health Department at the Macon Hospital. Four hour clinics held three times weekly are manned by Auxiliary members who assist in urinalysis, weighing, records, etc. Food demonstrations to expectant mothers are also given by the Auxiliary.

Mrs. J. R. S. Mays, president-elect to the Auxiliary of the Medical Association of Georgia, attended the National Conference of presidents and president-elects held in Chicago on Nov. 2 and 3.

Election of officers, scientific programs and a dinner dance highlighted the Sixth District Medical Society and its Woman's Auxiliary on Dec. 7. Mrs. Wm. Jordan was elected president of Bibb County Auxiliary.

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CHATHAM COUNTY: Dr. Howard J. Morrison spoke at a recent meeting on "Medicine in Europe," discussing information obtained on his trip to Europe last summer.

Mrs. David Robinson reported on the booth manned by the Auxiliary at the Coastal Empire Fair. Several thousand visitors visited the booth.

Mrs. John Elliott reported \$321.50 donated Cerebral Palsy School as proceeds from benefit card party sponsored by the Auxiliary.

A check for \$25.00 with other gifts was sent to the Tuberculosis Sanatorium for its Christmas party. Auxiliary members have helped and encouraged the sale of gifts made by patients at the tuberculosis hospital enabling them to buy gifts for their own families.

* * *

FLOYD COUNTY: Quarterly meeting was

held September 20 at the General Forest Hotel. After a short business session, followed by luncheon, Dr. Frank K. Boland of Atlanta gave an interesting review of his book, "The Story of Anaesthesia". He also gave the Auxiliary an autographed copy which is being passed around and read by the 22 members. Mrs. Frank K. Boland and Mrs. Kells Boland were special guests.

Members assisted the Floyd County Blood Bank in their booth at the Floyd County Fair, October 16 through 21. They did the book work and acted as receptionists.

One member, who is a Nurse's Aid, helped the County Health Department to organize an infant and maternity clinic this past summer.

Five members are on the Board of the Open Door Home, which is the only home for dependent children in Floyd County. One is on the Medical Committee, which is responsible for seeing that the children receive immunization.

Some of the members also helped the Cancer Clinic with their booth at the Fair. We have a few members who work with the Cancer Clinic throughout the year.

One of our members is co-chairman of the Speech School for children with defective speech. This school is sponsored by the Junior Service League. Other members give time to this project.

Last July we had a telephone committee to contact all the members and ask them to write their Congressman in regard to the Health Bill, in an effort to defeat it.

The Manager and Secretary of the Seventh District Medical Association are Romans and members of our Auxiliary. They are Mrs. Emmett Brannon, Pres. and Mrs. William Harbin, Jr., Secretary.

In September Mrs. Brannon presided over this district meeting, which was held at the Fairyland Club on Lookout Mountain and presented an interesting program, with Dr. Hal Davison from Atlanta as the speaker.

* * *

FULTON COUNTY: A panel discussion on "Civil Defense" was held at the November 3 meeting. The Auxiliary had the honor of bringing to the public of Atlanta the first coordinated explanation of Civil Defense. The meeting was at 10:30 a. m. at the Academy of Medicine, 875 West Peachtree Street. The speakers were: Col. Frank A. Kopf, Co-ordinator for Civil Defense for Georgia; Mr. George (Pup) Phillips, Director of Civil Defense for Atlanta Area; Dr. Charles E. Dowman, Defense and Preparedness Committee of Fulton County Medical Society; Dr. Edgar M. Dunstan, Moderator.

A motion picture was shown entitled "Tale of Two Cities, Hiroshima and Nagasaki".

The aim of the Woman's Auxiliary has always been to spread authentic health information

throughout the community. Because they consider national preparedness to be of vital importance to every citizen, they chose to present this program as their Health Education topic for the year.

Dr. Paul E. Schroeder spoke to the Auxiliary at the January 5 meeting on "The Psychiatric Influence on Medicine". This topic polished off another bright facet on the theme for this year, "The Physician's Contribution to Our Heritage".

* * *

GLYNN COUNTY: The Woman's Auxiliary to the Glynn County Medical Society entertained the doctors' wives of the Eighth District at the King and Prince Hotel, St. Simons Island on October 13.

Mrs. Enoch Callaway was a welcome visitor.

Our State President, Mrs. L. W. Williams of Savannah, was the speaker of the day and her talk on the duties of the different officials was most instructive.

* * *

MUSCOGEE COUNTY reports broadcast prepared by the American Medical Association "Way of Life" which ran 16 weeks (15 minutes) each Sunday. Another 30 minute broadcast, "The Wooden Fish", also by the A. M. A., was given over WGBA, Nov. 14.

The Auxiliary furnished 9 pair of pajamas for the Tuberculosis Hospital, also treats for patients' trays on holidays.

Workers manned Red Cross Booth for one week in the spring. Auxiliary went as a group for chest x-rays in the tuberculosis survey. Assisted in canvassing and as hostesses in survey.

Adopted their first constitution and by-laws.

Furnished cars for the city hospital nurses Recruitment program. A fund has been established to be used for a nurse's scholarship.

Health films have been shown in the public schools.

The Auxiliary entertained members of the Third District Medical Society November 3 at the Woman's Club. Mrs. L. W. Williams, state president, was honor guest.

* * *

RICHMOND COUNTY: The Auxiliary held a luncheon meeting in October at the Bon Air Hotel. Dr. Abe Davis spoke on "Tuberculosis, a Community Problem". Mrs. J. P. Hitchcock, president, welcomed guests from Camp Gordon and the Veterans Administration Hospital.

The Augusta area Cerebral Palsy Society reported \$1,046 from the party series initiated by Mrs. Joe Williams and Mrs. Perry Volpitto.

Mr. Robert C. Norman was guest speaker in November choosing as his topic "World Government". He emphasized the need for a "Federal Union of the Free", stating our best hope and first step toward this freedom is in the United Nations.

A Parental Guidance Course sponsored by the

Auxiliary last year proved so popular that it is being offered again this year in cooperation with the Richmond County Mental Hygiene Clinic. Classes will be in the evening so fathers may attend.

* * *

WARE COUNTY: The Auxiliary has sponsored a campaign to clean up vacant lots, business houses premises and streets. All organizations of the city cooperated in the drive with the result of a more attractive and cleaner city.

In October Mrs. J. E. Penland gave an interesting review of the development and growth of the Auxiliary and the part it has played in its help to the medical profession and its spread of health education to the public.

At the November meeting Mrs. Leo Smith presented an excellent paper on "Great Achievements in Medicine".

ELEVENTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

Hotel Atlanta Biltmore, Atlanta
Feb. 26-28, 1951

Sponsored by

The Council on Industrial Health of the
American Medical Association

The Medical Association of Georgia
and

The Fulton County Medical Society

MONDAY, FEBRUARY 26, 10:00 a. m.—BALLROOM

ANTHONY J. LANZA, M.D., New York City, *Presiding*

INVOCATION

THE REVEREND W. CANDLER BUDD, Atlanta

Welcome to Georgia

HAL M. DAVISON, M.D., President, Fulton County
Medical Society, Atlanta

A. M. PHILLIPS, M.D., President, Medical Association
of Georgia, Macon

A Tribute to Two Pioneers

JAMES E. PAULLIN, M.D., Past President, American
Medical Association, Atlanta

ROUND TABLE ON HEALTH FOR THE SOUTHERN WORKER—

THE SOUTH MEETS THE PROBLEM

JOSEPH T. SCOTT, JR., M.D., New Orleans, *Moderator*

Industrial Health Is a Community Problem

JOHN K. WILLIAMS, Executive Secretary, The Industrial
Health Council, Birmingham

An Organization for Small Plant Service

LESTER M. PETRIE, M.D., Director, Division of Industrial
Hygiene, Georgia Department of Public Health,
Atlanta

Essentials of Good Industrial Hygiene

JOHN M. McDONALD, M.D., Director, Division of Industrial
Hygiene, Florida State Board of Health,
Jacksonville

Expanding Industrial Health Needs Qualified Physicians

GRADIE R. ROWNTREE, M.D., Associate Professor of
Preventive Medicine and Public Health, University
of Louisville

Research

CARL A. NAU, M.D., Professor of Preventive Medicine
and Public Health, University of Texas, Galveston

New Experiences Foretell the Future

JEAN S. FELTON, M.D., Medical Director, Oak Ridge
National Laboratory, Oak Ridge, Tenn.

MONDAY, 12:15 p. m.—EMPIRE ROOM

LUNCHEON

Sponsored by the Local Committee on Arrangements

HOMER ALLEN, M.D., Decatur, *Presiding*

The Greater Atlanta Multiphasic Survey

LESTER M. PETRIE, M.D., Atlanta

MONDAY, 2:00-3:30 p. m.—BALLROOM

ECONOMIC POISONS

ROBERT A. KEHOE, M.D., Cincinnati, Presiding
This panel has been arranged with the Committee on
Pesticides of the American Medical Association.

PARTICIPANTS:

JUSTUS C. WARD, Pharmacological and Rodenticide
Section, Insecticide Division, U. S. Department of
Agriculture, Washington, D. C.

PAUL FITTS, Horticulturist, Cornelia

DONALD O. HAMELIN, M.D., Medical Director, Ameri-
can Cyanamid Company, New York City

J. B. KAY, M.D., Past President, Georgia Section,
American Academy of General Practice, Byron

MONDAY, 3:30-5:00 p. m.—BALLROOM

HAND INJURIES

HENRY H. KESSLER, M.D., Newark, N. J., Presiding

PARTICIPANTS:

CHARLES A. MILLER, Personnel Department, The Texas
Company, Houston

J. D. MARTIN, JR., M.D., Associate Professor of Sur-
gery, Emory University School of Medicine, Atlanta

ELKIN VOGT, M.D., General Practitioner, Lithonia

RICHARD D. CARR, LL.B., Secretary and Treasurer,
Georgia State Board of Workmen's Compensation,
Atlanta

MONDAY, 7:00 p. m.—BALLROOM

DINNER

ANTHONY J. LANZA, M.D., New York City, *Toastmaster*
Health, Industry and the Emergency

ELMER L. HENDERSON, M.D., President, American
Medical Association, Louisville

Rehabilitation—An Urgent Community Need

JAMES E. PAULLIN, M.D., Atlanta, Presiding

The handicapped, especially in times of emergency, are
a great national asset. Their records of productive
capacity compare very favorably with their able-bodied
brethren. This presentation, with assistance from the
handicapped themselves and from national and local
leaders, will demonstrate why Atlanta and every other
industrial community need to develop rehabilitation
services now.

TUESDAY, FEBRUARY 27, 10:00 a. m.—BALLROOM

ROUND TABLE ON THE CARDIAC IN INDUSTRY

CARTER SMITH, M.D., Atlanta, Presiding

PARTICIPANTS:

EDWARD S. ORGAIN, M.D., Associate Professor of Medi-
cine in Charge of Postgraduate Education and
Diseases of Metabolism, Duke University School of
Medicine, Durham, N. C.

H. T. HARPER, JR., M.D., Clinical Professor of Medi-
cine, University of Georgia School of Medicine,
Augusta

MAX R. BURNELL, M.D., Medical Consultant, General
Motors Corporation, Detroit

ARNOLD G. KENNEDY, American Federation of Labor,
Atlanta

CHARLES MATHIAS, Congress of Industrial Organiza-
tions, Atlanta

CHANNING COPE, Journalist, Atlanta

E. S. PAPY, White Provision Company, Atlanta

J. B. HOWARD, Assistant Plant Manager, Ford Motor
Company, Hapeville

HENRY L. BOWDEN, Past President, Atlanta Bar Asso-
ciation, Atlanta

H. L. WINGATE, President, Georgia Farm Bureau Fed-
eration, Macon

TUESDAY, 12:00 m.—EMPIRE ROOM

LUNCHEON

Sponsored by The Georgia Association of Industrial
Nurses and the Industrial Nurses Club of Atlanta

JOSEPHINE KINMAN, R.N., Atlanta, Presiding

Practical Partnership

GLADYS L. DUNDORE, R.N., Executive Secretary, Ameri-
can Association of Industrial Nurses, New York City

TUESDAY, 2:00 p. m.—BALLROOM

THE PHYSICIAN IN INDUSTRY AND THE EMERGENCY

JAMES S. SIMMONS, Brig. Gen., USA, MC, Ret., Boston,
Moderator

STEERING COMMITTEE ON INDUSTRIAL DEFENSE:

JAMES S. SIMMONS, M.D., Dean, Harvard School of
Public Health, Boston

ROBERT A. KEHOE, M.D., Kettering Laboratory, Uni-
versity of Cincinnati

HENRY H. KESSLER, M.D., Kessler Institute for Re-
habilitation, West Orange, N. J.

EDWARD H. CARLETON, M.D., Medical Director, Inland
Steel Company, East Chicago, Ind.

Committee consultants representing federal agencies
and others directly concerned will be invited to
attend.

*Report of Subcommittee on Defense—Disaster Blueprint
for the Industrial Physician*

CHARLES-FRANCIS LONG, M.D., Philadelphia, *Chairman*

*Report of Subcommittee on Manpower Conservation—
Industrial Health and Peak Production*

M. N. NEWQUIST, M.D., New York City, *Chairman*

WEDNESDAY, FEBRUARY 28, 9:00 a. m.—POMPEIAN ROOM

NOISE IN INDUSTRY

HOWARD P. HOUSE, M.D., Los Angeles, Presiding

(This program is arranged with the American Academy
of Ophthalmology and Otolaryngology and the Council
on Physical Medicine and Rehabilitation of the Ameri-
can Medical Association.)

Clinical Diagnosis of Occupational Acoustic Trauma

HOWARD P. HOUSE, M.D., Chairman of Subcommittee
on Noise in Industry, Committee on Conservation
of Hearing of the American Academy of Ophthal-
mology and Otolaryngology, Los Angeles

Environmental Aspects

Speaker to be announced

Clinical Study of Occupational Acoustic Trauma

DOUGLAS E. WHEELER, Ph.D., Field Representative of
Committee on Conservation of Hearing of the Ameri-
can Academy of Ophthalmology and Otolaryngology,
Los Angeles

Methods for Determining Percentage of Hearing Loss

HOWARD CARTER, Secretary, Council on Physical Medi-
cine and Rehabilitation, American Medical Asso-
ciation, Chicago

WEDNESDAY, 2:00 p. m.—POMPEIAN ROOM

INDUSTRIAL PULMONARY DUST DISEASES

LOYD E. HAMLIN, M.D., Chicago, Presiding

Etiology and Pathogenesis

KENNETH MERRILL LYNCH, M.D., Dean of the Medical
College of the State of South Carolina, Professor of
Pathology, Charleston

Clinical Diagnosis and Course

BURGESS L. GORDON, M.D., Clinical Professor of Medi-
cine, Jefferson Medical College of Philadelphia

Rehabilitation

OSCAR A. SANDER, M.D., Associate in Medicine, Mar-
quette University Medical School, Milwaukee

Engineering Control

CHARLES R. WILLIAMS, Ph.D., Liberty Mutual Insur-
ance Company, Boston

Multiphasic Screening Demonstration.

The Georgia Department of Public Health will have
one of its survey screening teams adjacent to the
meeting rooms to afford every one who cares to par-
ticipate an opportunity to go through the battery
of tests.

Small Plant Medical Service Demonstration.

Field trips will be arranged to the Petrie Clinic, a
cooperative small plant industrial medical service.

HEALTHGRAM

Mass mobile unit x-ray surveys have imposed a new
dual obligation upon the general practitioner. Deter-
mination of the activity or status of the frankly
tuberculous lesion, and differentiation of pulmonary
tuberculosis from other intrathoracic disease found in
mobile x-ray surveys are now almost invariably re-
sponsibilities of the family doctor. Coupled with these
duties, there still remains the necessity for early,
accurate diagnosis of tuberculosis of any case seen in
practice. Edwin J. Simons, M.D., and Edwin G.
Knight, M.D., *Journal-Lancet*, April 1950.

Postgraduate Course in Cardiology

EMORY UNIVERSITY SCHOOL OF MEDICINE

ATLANTA

MARCH 5-9, 1951

REGISTRATION FEE \$40.00

MONDAY, MARCH 5

8:30	Registration	
9:15	Role of Lipids in Atherosclerosis	<i>Dr. Bondy</i>
10:00	The Recognition of Coronary Insufficiency with Special Reference to Angina Pectoris	<i>Dr. White</i>
11:00	Intermission	
11:15	Treatment of Coronary Disease	<i>Dr. Logue</i>
12:15	Panel Discussion on Coronary Disease	<i>Dr. Claiborne, Moderator</i>
12:45	Lunch	
1:45	Vectoral Methods of Electrocardiographic Interpretation	<i>Dr. Hurst</i>
2:45	Clues in the Diagnosis of Cardiovascular Disease	<i>Dr. White</i>
3:45	Intermission	
4:00	Physiology of Congestive Heart Failure	<i>Dr. Warren</i>
4:45	Patient Presentations	<i>Dr. White</i>
TUESDAY, MARCH 6		
9:00	Management of Congestive Heart Failure	<i>Dr. Logue</i>
10:00	Normal and Abnormal Respiration	<i>Dr. Stead</i>
11:00	Intermission	

THURSDAY, MARCH 8

9:00	Indications for Cardiac Catheterization or Angiocardiology	<i>Dr. Warren</i>
10:00	Clues in the Differential Diagnosis of Congenital Heart Disease	<i>Dr. Logue</i>
11:00	Intermission	
11:15	Information Obtainable by Cardiac Fluoroscopy	<i>Dr. Leigh</i>
12:15	Progress in the Treatment of Subacute Bacterial Endocarditis	<i>Dr. Beeson</i>
12:45	Lunch	
1:45	Electrocardiography: Ventricular Hypertrophy and T Wave Abnormalities	<i>Dr. Hurst</i>
2:45	The Heart in Thyroid Disease	<i>Dr. Barrow</i>
3:45	Intermission	
4:00	Roentgenological Pulmonary Aspects of Heart Disease	<i>Dr. Weens</i>
FRIDAY, MARCH 9		
9:00	Electrocardiography: Myocardial Infarction	<i>Dr. Hurst</i>
10:00	Syncope	<i>Dr. Warren</i>
11:00	Intermission	

11:15	Hypertension—Types and Etiology	<i>Dr. Cargill</i>
12:15	The Optic Fundi in Cardiovascular Disease	<i>Dr. Calhoun</i>
12:45	Lunch	
1:45	Drug Therapy of Hypertension	<i>Dr. Barrow</i>
2:45	Dietary Treatment of Hypertension and Heart Failure	<i>Dr. Stead</i>
3:45	Intermission	
4:00	Patient Presentation	<i>Dr. Stead</i>
WEDNESDAY, MARCH 7		
9:00	Electrolyte Disturbances in Cardiovascular Disease	<i>Dr. Merrill</i>
10:00	Pulmonary Embolism and Infarction	<i>Dr. Stead</i>
11:00	Intermission	
11:15	Diagnosis and Management of Cardiac Arrhythmias	<i>Dr. Claiborne</i>
12:15	Pathogenesis of Acute Rheumatic Fever	<i>Dr. Beeson</i>
12:45	Lunch	
1:45	Differential Diagnosis of Acute Arthritis	<i>Dr. Michael</i>
2:45	Cortisone and ACTH in Acute Rheumatic Fever and Collagen Diseases	<i>Dr. Bondy</i>
3:45	Intermission	
4:00	Patient Presentation	<i>Dr. Stead</i>

11:15	Symptoms and Signs Misinterpreted as Heart Disease	<i>Dr. Logue</i>
11:45	Clinicopathological Conference	<i>Drs. James and Sheldon</i>
12:45	Lunch	
1:45	Electrocardiography—Bundle Branch Block and Intraventricular Conduction Defects	<i>Dr. Doyle</i>
2:45	Percardial Disease	<i>Dr. Hurst</i>
3:45	Intermission	
4:00	The Present Status of Cardiac Surgery	<i>Dr. Hopkins</i>
4:30	Cardiovascular Syphilis	<i>Dr. Heyman</i>

Detach slip below to make application for enrollment.

**To: Director of Postgraduate Education
Emory University School of Medicine
36 Butler Street, S. E.
Atlanta 3, Georgia**

Please enroll me in the Postgraduate Course in Cardiology, March 5-9, 1951.

Name

Address

AUGUSTA

in cooperation with

The Medical Association of Georgia

Announces A Postgraduate Course

NEWER DEVELOPMENTS IN MEDICINE

MARCH 20-23, 1951

Registration Fee, (\$20.00)

Minimal Registration 20 Maximal Registration 75

This course will present in concise fashion many of the trends and Newer Developments in the rapidly advancing field of Medicine. Special emphasis will be placed upon those developments in the various fields which have practical therapeutic applications. The "Pituitary adrenal-axis" and many of its recently discovered relationships will be included in both the Endocrinology and other sections.

Place of Meeting: The facilities of the Medical College of Georgia and those of the University Hospital, Augusta, will be used in this course.

Entertainment: A cocktail party will be given at the close of the first day. This will be held at the Bon Air Hotel. Wives accompanying their husbands are cordially invited.

Meals: Luncheon will be served in the Alumni Tavern daily for all registrants, courtesy of the College.

Hotel Accommodations: Bon Air Hotel. Mr. Walker, Mgr. Single rooms \$3.50 to \$5.00. Double rooms \$6.00 to \$8.00. Partridge Inn Hotel. Mr. Cannon, Mgr. Single rooms \$2.25 to \$5.00. Double rooms \$4.50 to \$7.00.

Special Note: Attendance in the course may be applied to the requirements for membership in the American Academy of General Practice.

TUESDAY, MARCH 20, 1951

9:00 - 10:00 Registration in the Lobby, Newton Building.

10:00 - 11:00 Movie—The Physiologic Bases for the action of ACTH in Human Beings.

11:00 - 12:00 Disorders of Adrenocortical Function

12:00 - 1:00 Collagen Diseases and Their Management

1:00 - 2:30 Lunch—Alumni Tavern.

2:30 - 3:00 Presentation of Cases.

A. a—ACTH in therapy of Stevens-Johnson syndrome

b—Cortisone in therapy of exophthalmos without thyrotoxicosis

B. ACTH and Cortisone in treatment of eczema in children

C. ACTH and Cortisone in treatment of anorexia nervosa and hypopituitarism

Dr. Greenblatt

Dr. Sydenstricker

Dr. Agostas

Dr. O'Rear

Dr. Barfield

4:00 - 5:00 Movie—The Therapeutic Use of ACTH in Human Disease.
6:30 - Get Acquainted Party—Cocktails

Bon Air Hotel

WEDNESDAY, MARCH 21, 1951

9:00 - 10:00 Peripheral Vascular Disease, Newer Therapeutic Measures Dr. Risten
10:00 - 11:00 Atherosclerosis (Genesis and Management) Dr. Harper
11:00 - 12:00 Physiological Mechanisms Involved in Congestive Heart Failure Dr. W. F. Hamilton
12:00 - 2:00 Lunch—Alumni Tavern.
2:00 - 3:00 Aureomycin, Chloromycetin, Terramycin and Penicillin Therapy Dr. Peskoe
3:00 - 4:00 Concepts of Cardiovascular Surgery Dr. Ellison
4:00 - 5:00 Newer Sympathomimetic Drugs and other Antibronchospasmodics Dr. Ahlquist

THURSDAY, MARCH 22, 1951

9:00 - 10:00 Methods of Diagnosis and Treatment in Allergic Diseases Dr. Thomas
10:00 - 11:00 Value and Limitations of Antihistaminic Drugs Dr. Kaufman
11:00 - 12:00 Therapy of the Leukemias and Lymphoblastomata Dr. Sydenstricker
12:00 - 2:00 Lunch—Alumni Tavern.
2:00 - 3:00 Use and Abuses of Transfusions Dr. Sheppard
3:00 - 4:00 Therapy of the Megaloblastic Anemias Dr. Sydenstricker
4:00 - 5:00 Implications of Atomic Energy Dr. W. F. Hamilton, Jr.

FRIDAY, MARCH 23, 1951

9:00 - 10:00 Diet Therapy in the Treatment of Hypertension and Nephritis Dr. Agostas
10:00 - 11:00 Newer Leads in Electrocardiography Dr. Harper
11:00 - 12:00 Infectious Hepatitis and Complications Dr. Gray
12:00 - 2:00 Lunch—Alumni Tavern.
2:00 - 3:00 Newer Drugs in the Treatment of Amebiasis Dr. Fader
3:00 - 4:00 Mental Depression, Including Shock Therapy and Its Indications Dr. Thigpen
4:00 - 5:00 The Common Denominator in the Functional Conditions of Everyday Practice Dr. Cleckley

Dr. Charles W. Hock, Director
Newer Developments in Medicine
Medical College of Georgia
Augusta, Georgia

I wish to be enrolled in Newer Developments in Medicine to be held in Augusta, Georgia, March 20-23, 1951.

Name_____

St. No._____

City_____

State_____

COUNTIES REPORTING FOR 1951

Banks County Medical Society
Member—Dr. J. S. Jolley, Homer

* * *

Carroll-Douglas-Haralson Medical Society
President—Dr. William P. Downey, Tallapoosa
President-Elect—Dr. F. W. Morgan, Douglasville
Vice-President—Dr. Roy L. Denney, Carrollton
Secretary-Treasurer—Dr. D. S. Reese, Carrollton

* * *

Dougherty County Medical Society
President—Dr. Charles M. Holman, Albany
Vice-President—Dr. Charles S. McCall, Jr., Albany
Secretary-Treasurer—Dr. Paul T. Russell, Albany
Delegate—Dr. Paul T. Russell, Albany
Alternate Delegate—Dr. W. Frank McKemie, Albany
Censors—Dr. J. M. Barnett, Dr. J. C. Keaton, and
Dr. J. A. Redfearn, all of Albany

* * *

Franklin County Medical Society
President—Dr. Stewart D. Brown, Royston
Secretary-Treasurer—Dr. E. T. Poole, Lavonia
Delegate—Dr. Stewart D. Brown, Royston
Alternate Delegate—Dr. Robert E. Ridgway, Royston

* * *

Glynn County Medical Society
President—Dr. Ira G. Towson, Sea Island
Vice-President—Dr. H. L. Moore, Brunswick
Secretary-Treasurer—Dr. T. H. Johnston, Brunswick
Delegate—Dr. C. A. Wilson, Jr., Brunswick
Censors—Dr. James M. Hicks, Dr. Frank B. Mitchell,
Jr., and Dr. S. P. McDaniel, all of Brunswick

* * *

Jenkins County Medical Society
President—Dr. James C. Freeman, Sylvania
Secretary-Treasurer—Dr. A. P. Mulkey, Millen
Alternate Delegate—Dr. Q. A. Mulkey, Millen

* * *

Meriwether-Harris Medical Society
President—Dr. Stuart Raper, Warm Springs
Vice-President—Dr. Thomas Gucker, III, Warm
Springs
Secretary-Treasurer—Dr. R. B. Gilbert, Greenville
Delegate—Dr. Robert L. Bennett, Warm Springs
Alternate Delegate—Dr. R. B. Gilbert, Greenville

* * *

Mitchell County Medical Society
President—Dr. A. A. McNeill, Jr., Camilla
Vice-President—Dr. J. G. Crovatt, Camilla
Secretary-Treasurer—Dr. D. P. Belcher, Pelham
Delegate—Dr. J. C. Brim, Pelham
Alternate Delegate—Dr. Edwin M. Walker, Pelham

* * *

Randolph-Terrell Medical Society
President—Dr. C. Marion Pugh, Lumpkin
Vice-President—Dr. Robert B. Quattlebaum, Ft. Gaines
Secretary-Treasurer—Dr. W. G. Elliott, Cuthbert
Delegate—Dr. Ernest F. Daniel, Dawson
Alternate Delegate—Dr. J. C. Tidmore, Dawson
Censors—Dr. F. S. Rogers, Coleman, Dr. A. R. Sims,
Richland, and Dr. J. C. Tidmore, Dawson
PR Chairman—Dr. Steve P. Kenyon, Dawson

* * *

Rockdale County Medical Society
Secretary-Treasurer—Dr. Harvey E. Griggs, Conyers

* * *

Tattnall County Medical Society
President—Dr. J. M. Hughes, Glennville
Vice-President—Dr. L. V. Strickland, Cobbtown
Secretary-Treasurer—Dr. A. G. Pinkston, Jr., Glennville
Delegate—Dr. A. G. Pinkston, Jr., Glennville
Censors—Dr. A. G. Pinkston, Jr., Glennville, Dr. J. C.
Collins, Collins, and Dr. L. R. Jelks, Reidsville

* * *

Telfair County Medical Society
President—Dr. F. A. Smith, Jr., McRae
Vice-President—Dr. S. T. Parkerson, McRae
Secretary-Treasurer—Dr. F. R. Mann, Sr., McRae

Delegate—Dr. F. R. Mann, Jr., McRae
Alternate Delegate—Dr. C. J. Maloy, McRae
Censors—Dr. F. R. Mann, Sr., Dr. W. H. Born and
Dr. C. J. Maloy, all of McRae

* * *

Tri-County Medical Society
(Calhoun-Early-Miller Counties)
President—Dr. J. H. Crowdis, Jr., Blakely
Vice-President—Dr. James B. Martin, Edison
Secretary-Treasurer—Dr. Hinton J. Merritt, Colquitt
Delegate—Dr. W. O. Shepard, Bluffton
Alternate Delegate—Dr. J. G. Standifer, Blakely
Censors—Dr. James W. Merritt, Dr. Turner W. Rentz,
both of Colquitt, and Dr. W. H. Wall, Blakely.

NEWS ITEMS

The Atlanta Eye, Ear, Nose and Throat Society recently held its election of officers for 1951. They are Dr. Edward S. Wright, Atlanta, president; Dr. Phinizy Calhoun, Jr., Atlanta, vice president, and Dr. James T. King, Atlanta, was re-elected secretary and treasurer.

* * *

Dr. David Nye Barrows, New York City, director of Gynecology and Medical Executive Officer of the New York Polyclinic Medical School and Hospital, has been made Dean of the institution as of January 1, 1951. Dr. Barrows also holds a position as Clinical Gynecology and Obstetrics at New York University College of Medicine, New York City.

* * *

Dr. Max M. Blumberg, Atlanta, announces the removal of his offices to 1208 West Peachtree Street, N. W., Atlanta. Practice limited to internal medicine.

* * *

Dr. Clyde A. Burgamy, Sylvania physician, recently volunteered for service in the U. S. Navy Medical Corps, and has been ordered to report to the commanding general at Parris Island Marine Base, Parris Island, S. C., where he received a commission as Lieutenant (jg).

* * *

Dr. R. Frank Cary, Macon, Macon-Bibb County Health Officer, has been commissioned local vital statistics registrar for Bibb County by the Georgia Department of Public Health, effective January 1.

* * *

The Cobb County Medical Society held its December meeting at the Kennestone Hospital, Marietta. The following officers for 1951 were elected: Dr. E. A. Musarra, Marietta, president; Dr. Charles M. Garland, Smyrna, vice president, and Dr. Bruce Burleigh, Marietta, secretary-treasurer. Dr. W. H. Benson, Marietta, is the past president.

* * *

Dr. W. Barron Crawford, Jr., Savannah physician, was recently elected president of the staff of St. Joseph's Hospital for 1951. Other officers elected are: Dr. R. L. Oliver, vice president, Dr. Jules Victor, Jr., secretary, and Dr. Alexander Paderewski, treasurer.

* * *

Dr. Asa W. DeLoach, a native of Savannah, is associated with Dr. Charles T. Brown, Jr., Brown Clinic, Guyton, for the practice of medicine and surgery. He graduated from the Medical College of Georgia, Augusta, in 1946, interned at the John Sealy Hospital of the University of Texas School of Medicine, Galveston, Texas, where he also took a fellowship in surgery. He was a captain in the U. S. Army Air Force Medical Corps from 1948 to 1950.

* * *

The Fourth District Medical Society held its quarterly meeting at the Newnan Country Club, Newnan, December 12. Dr. C. C. Elliott, Sargent, president of the Coweta County Medical Society, was in charge of the program. Dr. N. B. Glover, Newnan, presented a paper on "Pediatric Emergencies", and Dr. Paul Rieth, Atlanta, discussed "Low Back Pain." The following officers for 1951 were elected: Dr. Hilt Hamilton, Jr., LaGrange, presi-

dent; Dr. C. W. Harvey, Hogansville, vice president, and Dr. James Bryant, Newnan, secretary-treasurer. Dr. J. W. Chambers, LaGrange, was named Trustee for the West Georgia Cancer Clinic, LaGrange, for 1951.

* * *

The Fulton County Medical Society held its semi-monthly dinner meeting at the Academy of Medicine, Atlanta, February 1. Scientific Program: Dr. Paul Beeson, moderator. "Thromboembolic Disease," Dr. Bruce Logue. "Pronestyl Therapy in Arrhythmias and Allergic Disorders," Dr. Gratton C. Woodson.

* * *

Dr. Alton V. Hallum, Atlanta, announces the removal of his offices to 245 Doctors Building, 490 Peachtree Street, N. E., Atlanta. Practice limited to ophthalmology.

* * *

The Georgia Medical Society held its regular meeting at 612 Drayton Street, Savannah, January 9. Program: "The Injection Treatment of Hemorrhoids, Kodachrome Slides," Dr. Leonard J. Rabhan. Open discussion. Dr. Lawrence Lee, Jr., secretary.

* * *

The International College of Surgeons, United States Chapter, Southern Section Assembly met at the Academy of Medicine and the Biltmore Hotel, Atlanta, January 11-12. Dr. William Perrin Nicholson, Atlanta, was general chairman, and presided at the opening session. Dr. T. C. Davison, Atlanta, co-chairman, also presided. Other Atlanta physicians presiding were: Dr. Hal M. Davison, President of Fulton County Medical Society, Dr. Walter W. Daniel, Dr. Spencer A. Kirkland, Dr. B. T. Beasley and Dr. A. H. Letton. Georgia physicians participating in the program were: Dr. Calvin Stewart, Atlanta. "Cancer of the Mouth" was the subject of his paper. Dr. Exum Walker, Atlanta, read a paper entitled "The Diagnosis and Surgical Treatment of Cervical Intervertebral Disc Lesions." On January 12 at the Biltmore Hotel luncheon for all members of the International College of Surgeons in Georgia a Georgia Chapter of International College of Surgeons was organized. Officers elected were: Dr. William Perrin Nicholson, president; Dr. B. T. Beasley, vice-president, and Dr. A. H. Letton, secretary-treasurer.

* * *

The Georgia Society of Ophthalmology and Otolaryngology will hold its annual meeting at the General Oglethorpe Hotel in Savannah, March 2 and 3, 1951.

Members and their guests are invited to make their reservations directly with the Hotel. Registration fee for the lectures is \$20.00.

The Lecturers and their subjects are: Dr. A. D. Ruedemann, Detroit, Mich., "Cataracts as a Medical Problem and Selection of the Type of Operation in Cataract Surgery," Dr. Peter C. Kronfeld, Chicago, Ill., "Diagnosis and Medical Treatment of the Glaucomas," and "The Surgical Treatment of the Glaucomas," Dr. William C. Owens, Baltimore, Md., "Surgical Treatment Horizontal Muscle Deviations and Surgical Treatment of Vertical Deviations," Dr. C. Stewart Nash, Rochester, N. Y., "Functional Diseases of the Nose and Otolaryngologic Mishaps," Dr. Philip Meltzer, Boston, Mass., "Simple, Practical Therapeutic Measure in Otic Practice—Surgical," and "The Conservation of Hearing in Chronic Suppurative Otitis Media," Dr. Edwin C. Broyles, Baltimore, Md., "Tumors of the Larynx—Benign and Malignant and Summary of Otolaryngologic Conditions that Require Expert Attention."

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Dr. Hubert U. King, formerly of Nicholls, has accepted the position of Public Health Commissioner for Whitfield and Murray Counties with offices in Dalton. Dr. King was associated with the Georgia Department of Public Health with offices in Waynesboro before moving to Dalton. He graduated from the Medical College of Georgia, Augusta, in 1947.

* * *

Dr. George M. Lane, a native of Lincolnton, announces

his association with Dr. Lincoln P. Elam, Jr., Sparta, for the practice of medicine. Drs. Lane and Elam were classmates at the Medical College of Georgia, Augusta, and both are natives of Lincolnton.

* * *

The Laurens County Medical Society held its annual dinner meeting at the Dublin Country Club, Dublin, December 15. Dr. Jerry P. Woodhall, a Macon surgeon, was guest speaker. His subject was "Newer Surgical Treatment of Diseases of the Blood Vessels." The following officers were elected for 1951: Dr. M. Fernan-Nunez, president; Dr. Charles A. Hodges, vice-president; and Dr. O. H. Cheek, secretary-treasurer for the 27th successive year in this office. Dr. J. A. Bell was appointed delegate to the annual session of the Medical Association of Georgia to be held in Augusta, April 17-20.

* * *

Dr. Dean Sherwood Luce, of Canton, Mass., was named "Family Doctor of Year" at the fourth clinical session of the American Medical Association held in Cleveland, O., December 5-8, 1950. The 74-year-old general practitioner, still "on the job" in Canton said: "I feel very humble about this whole thing. There are many men just as worthy of the honor as I am." On socialized medicine, Dr. Luce said: "Some doctors provide arguments for socialized medicine by overcharging and by refusing to provide out services. A man should not consider the dollar in the practice of medicine . . . I never made a lot of money out of it and never intended to."

* * *

Dr. Salmon A. Koff, Atlanta, announces the opening of his offices at Suite 523, 805 Peachtree Street Building, Atlanta. Practice limited to psychiatry. Special interest in psychotherapy.

* * *

Dr. Calvin S. Meeks, Douglas physician, has been called to active duty with the U. S. Air Force and reported to Hunter Field, Savannah, January 2. Dr. Meeks is assigned to the Second Bomber Group and will re-enter the service as first lieutenant. Dr. Meeks served with the Navy in World War II.

* * *

Dr. Charles K. Richards, Calhoun physician, is taking a year's training in surgery at the Erlanger Hospital, Chattanooga, Tenn. He will continue his Calhoun practice of medicine on a part-time basis. His schedule permits him to devote one to four days a week in Calhoun.

* * *

The Southern States Seminar on Chronic Diseases sponsored by U. S. Public Health Services was held at the Academy of Medicine, Atlanta, January 13 and 14. Georgia physicians taking part on the program were: Dr. Hal M. Davison, Atlanta, president of Fulton County Medical Society; Dr. J. F. Hackney, Atlanta, director of the City Health Department; Dr. L. M. Petrie, Atlanta, director, Division of Industrial Hygiene, Georgia Department of Public Health. Dr. Robert L. Bennett, Warm Springs, Georgia Warm Springs Foundation; Dr. Tully T. Blalock, Atlanta, Internist, and president, Georgia Hospital and Health Council; Dr. T. F. Sellers, Atlanta, director, Georgia Department of Public Health; Dr. C. D. Bowdoin, Atlanta, director, Division of Preventable Disease Control, Georgia Department of Public Health; Dr. James E. Paullin, Atlanta, Internist, and Dr. F. W. Sunderman, Atlanta, chief, Clinical Laboratories, Communicable Disease Center, U. S. Public Health Service.

* * *

Dr. V. P. Sydenstricker, Augusta, professor of medicine, Medical College of Georgia, has been given a government grant of \$10,000 for research to improve treatment of severe burns. The announcement made from Washington said that the study would cover burns such as could occur in bombing attacks. This grant is another in a long list of recognitions given Dr. Sydenstricker by this and other governments. Last September Dr. Sydenstricker went to Europe to act as consultant to conferences of the World Health Organization in

London, Geneva and Dublin. He is probably the best informed physician in the whole world in the field of nutrition and is constantly being consulted by members of his profession from all over the world.

* * *

The Toombs County Medical Society held its annual meeting at the Green Acres Country Club, Vidalia, December 19. Members of the society and their wives were guests. Dr. J. E. Mercer, Vidalia, president.

* * *

Dr. Frank Vinson, Fort Valley, announces the association of Dr. W. W. Cox in the practice of medicine. Dr. Cox is a native of Gulfport, Miss., and graduated from the University of Tennessee College of Medicine, Memphis, in 1946. He is a reserve officer in the U. S. Air Force with the rank of captain.

* * *

The Veterans Administration Hospital (Lenwood), Augusta, recently announced that Dr. Louis Wender, Katonah, N. Y., associate physician in charge at Pine-wood Sanitarium, gave two lectures on the subject of "Group Psychotherapy." Dr. Wender has had previous experience as superintendent of Corozal Hospital in the Canal Zone, instructor in psychiatry at Columbia, and medical director of Hillside Hospital, Bellerose, Long Island. He introduced group psychotherapy in the early thirties and has published many papers and given many lectures on the subject since that time. Dr. Leo R. Tighe, Augusta, is manager of the VA Hospital (Lenwood).

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Dr. Bernard P. Wolff, Atlanta physician, and assistant professor of medicine at Emory University School of Medicine, spoke on "Nursing Care in Atomic Warfare" at a meeting of the Industrial Nurses Club, Atlanta, December 12. Dr. Wolff is chairman of the committee on Civil Defense of the Fulton County Medical Society.

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Dr. T. C. Davison, Atlanta, as president of the American Goiter Association, addressed the Medical Study Club of Orlando, Fla. by special invitation, January 18. His subject was "Diseases of the Thyroid."

* * *

Dr. Murdock Equen, Atlanta, recently returned from the Council meeting of the American Broncho-Esophageological Association held in Philadelphia, Pa.

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Dr. Amey Chappell, Atlanta, is vice-chairman of the Women Physicians of the Southern Medical Association.

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The Fulton County Medical Society held its semi-monthly dinner meeting at the Academy of Medicine, Atlanta, January 18. Scientific Program: Dr. William W. Bryan, moderator. "Congenital Atersia of the Esophagotracheal Fistula." Dr. C. Richard King. "Use of Cortisone and ACTH in Ophthalmology," Dr. Morgan B. Raiford.

OBITUARY

Dr. Will James Auten, aged 85, lifelong Atlantan and retired practicing physician for more than 50 years, died at his Atlanta home, December 25, 1950. He graduated from the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1888. Dr. Auten was Fulton County physician for many years and was for about 30 years physician for the Atlanta Crackers. He was a member of the Warren A. Candler Methodist Church. At the annual session of the Medical Association of Georgia held in Savannah in 1949, Dr. Auten was presented with a Certificate of Merit and a gold lapel button for his more than 50 years as a practicing physician along with other Georgia physicians. Surviving are a son, Will J. Auten, Jr., Los Angeles, Calif.; a daughter, Mrs. George F. Stewart, Atlanta; three grandchildren, and three great-grandchildren. Funeral services were held at the chapel of Henry M. Blanchard & Son with the Rev. Marvin C. Allen officiating. Burial was in West View Cemetery, Atlanta.

Dr. James Gaston Gay, aged 53, Atlanta surgeon, died at his residence, 2594 Howell Mill Road, N. W., January 22, 1951. Dr. Gay a native Atlantan, graduated from Johns Hopkins University School of Medicine, Baltimore, Md., in 1923. He interned at Johns Hopkins University, and spent four years at the Mayo Clinic, Rochester, Minn. He was an authority on thyroid gland operations. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, and a diplomate of the American Board of Surgery. He was also a member of the First Presbyterian Church, Palestine Masonic Lodge, and the Piedmont Driving Club. Survivors include his wife, the former Margaret McIntyre, of Atlanta; two daughters, Miss Julie Gay and Miss Elizabeth Gay, both of Atlanta; one sister, Mrs. Eloise Brawley, Decatur; and one brother Dr. T. Bolling Gay, Atlanta. Funeral services were held at Spring Hill with Dr. William V. Gardner officiating. Burial was in West View Cemetery, Atlanta.

* * *

Dr. Frank J. Giuffrida, Sr., aged 70, Atlanta physician, died at his residence, 105 Briarcliff Circle, N. E., after a long illness, December 21, 1950. A native of Augusta, Dr. Giuffrida graduated from the Atlanta School of Medicine, now Emory University School of Medicine, Atlanta, in 1910. He came to Atlanta in 1907. Dr. Giuffrida was credited with being the first doctor to volunteer for active duty at the beginning of World War I from the Atlanta area. Surviving are his wife; daughters, Mrs. James Knight, Mrs. R. J. Moore, Mrs. C. E. Turner, Mrs. Victor Bentar, of Atlanta; Mrs. E. W. Smith, New York City; sons, F. J. Giuffrida, Jr., Atlanta; E. A. Giuffrida, Albany, and several grandchildren. Funeral services were held at Spring Hill with the Rev. W. M. Frampton, Anderson, S. C., officiating. Burial was in Greenwood Cemetery, Atlanta.

* * *

Dr. Thomas E. Green, aged 72, Chatsworth physician, died in a private hospital, January 21, 1951. Born in Murray County, where he spent most of his life, he graduated from the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1900. He was a lieutenant in World War I. He was the third doctor in his family in as many generations. Dr. Green, along with more than 50 other Georgia physicians, received a Certificate of Merit from the Medical Association of Georgia in 1950. Surviving are two daughters, Mrs. Henry Rust Felix, Mrs. William Minelli, both of Tampa, Fla.; three sisters, Mrs. Stephen T. Brown, Mrs. S. Ross Brown, both of Atlanta, and Mrs. Cliff Johnson, of Andersonville. Funeral services were held at the Fred Brown Funeral Home, Chatsworth, with the Rev. W. L. Rainwater officiating. Burial was in Tredwell Cemetery, Spring Place.

* * *

Dr. Julian G. Riley, aged 51, one of Atlanta's outstanding surgeons, died at his residence, 509 West Paces Ferry Road, N. W., after an illness of several months, January 12, 1951. Dr. Riley was born in Orangeburg, S. C., January 12, 1900, and was graduated from Emory University School of Medicine, Atlanta, in 1922. He interned at St. Joseph's Infirmary, Atlanta, and later spent two years in special work at Women's Hospital, in New York City. Dr. Riley was a member of the Fulton County Medical Society, the Medical Association of Georgia, American Medical Association and the Southeastern Surgical Congress. He held a fellowship in the American College of Surgeons. He was a member of the Cathedral of Christ the King, Piedmont Driving Club, Nine O'clock Club, Capital City Club, and the Peachtree Golf Club. He was a commander in the medical corps of the Navy during World War II. Survivors include his wife, the former Miss Katherine Murphy, of Atlanta; three sisters, Mrs. H. Way Marsh, Lexington, N. C.; Mrs. Grice Hunt, Greenville, S. C., and Mrs. Lillian R. Hart, New York City; a brother, James B. Riley, Kissimmee, Fla. Funeral services were held at the Cathedral of Christ the King, Rev. Father John Emmerth officiating. Burial was in Oakland Cemetery, Atlanta.

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PROLAPSE OF THE GASTRIC MUCOSA

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Atlanta

Until the last few years, prolapse of the gastric mucosa through the pylorus into the duodenal cap had received but scant attention as a condition of clinical significance. Although a case of prolapse of the gastric mucosa through the pyloric canal was reported by Von Schmieden¹ in 1911, recognition of the condition was not published in this country until 1925 when attention was called to it by Eliason and Wright². In a review of the literature to 1947 Manning and Highsmith³ found reports of 37 cases, the majority of which had been confirmed at operation. Since 1947 over 100 additional cases have been reported in 13 articles^{3 4 5 6 7 8 9 10 11 12 13 14 15} four of which appeared during 1950.

In December 1947 at the Southern Surgical Association meeting, Ira A. Ferguson⁷ reported six cases of prolapse of the gastric mucosa. At that time H. S. Weens¹⁶ had reported to him that in a review of the last 297 examinations of the upper gastrointestinal tract made at Grady Memorial Hospital and Emory University Hospital, 23 cases of prolapse of gastric mucosa were found, which was an incidence of 7.7 per cent.

This condition occurs much more frequently in males than in females, in about

the same ratio as that found in duodenal ulcer. This condition has been found in patients ranging from 19 years to 82 years of age.

Etiology

The etiology of prolapse of the gastric mucosa is unknown but a knowledge of the anatomy and physiology of movement of the stomach makes the proposed theories more understandable. As we all know, the wall of the stomach is composed from without, inward of serosa, tunica muscularis, sub-mucosa, and mucosa. The muscularis mucosae lies on the inner margin of the sub-mucosa and sends strands of muscle fibers into the mucous membrane. The surface of the mucous membrane is thrown up into folds called rugae. These folds vary in size and form in different individuals, and in the same individual they vary to a certain extent with change of position, becoming more irregular in the horizontal than in the erect position. In 1923 Forssell¹⁷ reported evidence suggesting that the gastric mucosal folds were not fixed, anatomic structures, but instead were variable in form and relationship, that they frequently, if not constantly changed and that this change in the folds was produced by the muscularis mucosae, which has the ability to move independently of the tunica muscularis. Ross Golden¹⁸ has presented arguments in favor of this independent movement of the mucous membrane over the muscle. The lower half of the stomach, particularly the antrum, is the motor portion. The peristaltic wave passes down the stomach as a narrow indentation on the lesser curvature and a wider,

Read at the meeting of Fulton County Medical Society, Atlanta, November 16, 1950.

Winner of the L. C. Fisher Award for the best prepared paper presented before the Fulton County Medical Society in 1950.

shallower indentation on the greater curvature. As the wave passes into the antrum its impression on the greater curvature becomes deeper; the trailing edge of the wave slows up or stops, and the advancing edge increases in speed, closing off a variable portion of the lower end of the stomach, and usually results in the expulsion of gastric contents. This is known as the antral systole. It is produced by contraction of the circular muscle and contraction of the longitudinal muscle toward the pylorus. Golden¹⁸ has pointed out that before antral systole, the mucosal folds in the antrum frequently may be seen running irregularly transverse to the axis of the stomach. When the antral systole takes place these folds change direction, run neatly parallel with the long axis and seem to become very thin and slender. For this change to occur, a movement of the mucous membrane in a cephalad direction must take place, thereby stretching it beneath the contracted muscle. Otherwise as the antrum closes off and shortens, the criss-cross folds would be exaggerated, pushed down in a caudad direction and jammed toward the pylorus. Golden¹⁸ thinks the failure of this stretching mechanism may account for the herniation of mucosal folds through the pylorus. Even if this is not the whole answer, it seems to fit in well with other theories that have been advanced. The oldest theory is that hypertrophic gastritis precedes prolapse of the gastric mucosa. A later theory is that there is a narrowing of the pyloric lumen which stimulates hyperperistalsis leading to loosening of the submucosa with prolapse of the gastric mucosa, and with the development of gastritis being secondary. More recently the theory has been advanced that the increased motility may be initiated by neurogenic or chemical stimulæ on a psychosomatic basis.

Symptoms

Prolapse of the gastric mucosa does not

cause a characteristic symptom-complex. Therefore, it is rarely possible to make a clinical diagnosis of this condition. However, the symptoms produced, do point to the upper gastrointestinal tract, thus indicating roentgenographic studies by which the diagnosis is made. The variety of symptoms is influenced by the extent and condition of the prolapsed mucosa. Pain is the most consistent single symptom, usually being aching or cramp-like in character. The pain is usually felt in the epigastrium and frequently radiates under the costal margin or to the back. At times it may be prostrating. It is more often relieved by food than by antacids. The pain is intermittent, as are other symptoms including nausea, vomiting, sour belching, heart burn, fullness and gaseous distention. Varying degrees of gastric retention may be present at times. Anorexia, anemia, and loss of weight also may occur. In reviewing about 100 cases of prolapse now reported in the literature, Artz and Gants¹⁴ found that 12 were complicated by severe hematemesis and melena.

Diagnosis

Roentgenographic examination is required to establish a definite diagnosis. A central umbrella-like negative shadow appearing as a filling defect at the base of the duodenal bulb is typical. Inasmuch as the stage and degree of prolapse may vary at different times, repeated x-ray examinations may be required to establish a definite diagnosis. If the examination is performed in a quiescent period the mucosal folds may not prolapse through the pyloric ring to present the typical deformity. Multiple examinations, preferably during an exacerbation of symptoms are recommended.

Scott¹⁹ has outlined the following points in the roentgenologic diagnosis: (1) the filling defects in the duodenal bulb are invariably in the base, immediately around the

pyloric opening; the redundant folds produce a central mushroom-like negative shadow, of a lobulated appearance; (2) the filling defects vary in size, shape and appearance in the single examination and on repeated examinations because of the changes in the degree of prolapse, in contradistinction to the findings associated with duodenal ulcers which are constant during any one examination; (3) the redundant gastric rugae can be traced from the antral canal through the pyloric opening into the base of the duodenal bulb; (4) the duodenal bulb is not irritable in prolapsed mucosa, in contradistinction to the findings associated with an active ulcer; (5) gastric peristalsis is more vigorous than normal; (6) fluoroscopy must be supplemented by serial "spot films" or prolapse may be overlooked; and (7) although some authors advise examination of the patient in the prone position, the prolapsed folds can be demonstrated with the patient erect.

Pedunculated prolapsed gastric polypi are most often confused with prolapsed mucosa. Differential diagnosis must also include duodenal ulcer, papilloma of the duodenum, hypertrophic types of gastritis and adult hypertrophy of the pyloric muscle.

Treatment

The management of the patient with prolapsed mucosa depends on the extent of the lesion and the severity of the symptoms. In slight or moderate prolapse a thorough trial on a peptic ulcer-type regimen is indicated. As stated previously, up to 1947 most of the cases reported had been confirmed surgically. However, since then, there has been a much smaller percentage of cases going to surgery. In none of the 16 cases reported by Manning and Highsmith³ was surgical intervention considered necessary. Cove and Curphey¹⁰ reported that 5 of their 22 patients underwent operation with relief of symptoms. Ferguson⁷ reported that of the

23 cases found at Grady Memorial Hospital and Emory University Hospital, 4 were so extensive as to indicate eventual surgical treatment.

The indications for surgery in this condition are much the same as they are for duodenal ulcer, i.e. obstruction, hemorrhage and persistence of pain after adequate medical therapy. If a prolapsed pedunculated gastric tumor or polyp cannot be excluded from the differential diagnosis, surgical exploration may be required to rule out malignancy.

Several types of operations have been advocated but recent reports have favored the simple removal of the excess mucosa followed by a Heineke-Mikulicz or Finney-type pyloroplasty.

Report of Cases

Case 1. Mr. H. M., a 52 year old maintenance engineer had had heart burn for three or four years. For over one year he had had intermittent epigastric burning, griping pain. In December 1948, he had seen a physician who made a diagnosis of duodenal ulcer without an ulcer crater being demonstrated on x-ray examination. When first seen by me on November 28, 1949 he had had an exacerbation of his symptoms for two weeks. The epigastric pain began between one half and one hour after meals and was only partially relieved by milk or antacids. At times the griping pain was severe enough to double him up. It was easier when he would lie on his abdomen but the pain would begin to gnaw again when he turned on his back. In addition to the epigastric pain he had episodes of retroxiphoid cramping pain with nausea and vomiting.

Roentgenographic examination of the gastrointestinal tract at my office revealed a hiatus hernia, pylorospasm and a deformed duodenal cap, but no ulcer crater. Gastric analysis after Ewald test meal revealed 85 degrees of free HCl with four plus occult blood.

He was placed on an ulcer regimen with rest at home but he did not improve satisfactorily. Before Christmas he had emeses of coffee colored thin liquid. He did not consent to hospitalization until December 27, 1949.

On December 29 roentgenographic examination by Dr. J. D. King at Crawford Long Memorial Hospital revealed a hiatus hernia, pylorospasm and prolapse of the gastric mucosa into the duodenal cap. Repeat examination the next day verified the prolapse.

Even on a strict regimen with bed rest in the hospital his symptoms did not subside. Therefore, an operation was advocated and the patient consented. On January 6, 1950, about an hour before the surgeon was to see him, he left the hospital against medical advice and since then has not consulted me. However, in August he brought an insurance form to me to be completed and at that time stated that he was still having intermittent epigastric pain.

Case 2. Mr. J. T. H., a white, male welder, aged 25 years began to have stomach trouble about six months after he was medically discharged from the Navy in September 1944, because of fallen arches and an old deformity of his hip. At first his dyspepsia consisted of mid-abdominal hurting and burning with some belching. His physician made a roentgenographic examination and

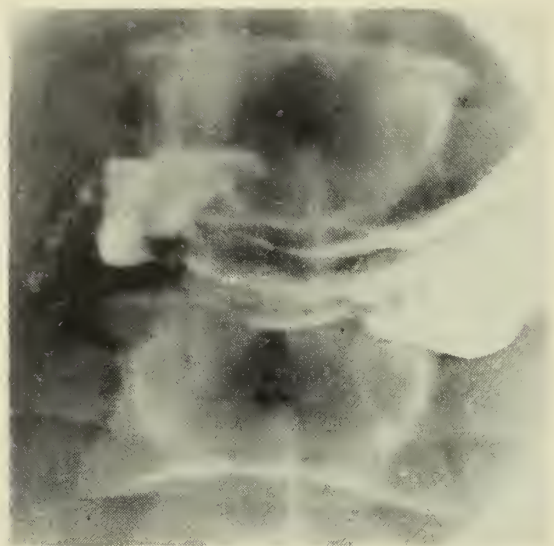


Fig. 1 (case 2).—Spot film made with patient standing which shows prominent antral rugal folds and prolapse of the gastric mucosa into the duodenal cap producing an umbrella-like deformity.



Fig. 2 (case 3).—Spot film made with patient standing which shows antral spasm and prolapse of the gastric mucosa into the duodenal cap producing a mushroom-like deformity.

finding no ulcer treated him for hyperchlorhydria. In July 1946 he was hospitalized at Veterans Administration Hospital 48 where roentgenographic studies again failed to reveal an ulcer but he was retained on an ulcer regimen for 30 days. A year later he consulted another physician who sent him to a roentgenologist who found pylorospasm but no ulcer. After that he was treated by a physician in a nearby town and later by another Atlanta physician.

When first seen by me on May 22, 1950 he was complaining of spells of epigastric cramping colic which occurred in the morning. Symptoms were less after a mild breakfast but worse if he ate sausage. On arising he had nausea without emesis, but with eructations of sour material. He rarely had dyspepsia in the afternoon. At times he went a week without any symptoms.

Roentgenographic studies revealed slightly prominent rugae in the antral region of the stomach with a mushroom deformity in the duodenal cap due to prolapse of the gastric mucosa. Gastric analysis after Ewald test meal revealed 78 degrees of free HCl with no blood present in the secretion. He was given an ambulatory peptic ulcer regimen. Three weeks later he reported he had been asymptomatic since the examination.

This case illustrates two points that I would like to emphasize: first, the intermittent nature of this condition and second, the possibility that several roentgenographic studies may not show the prolapse. In fact, the diagnosis cannot be made unless the study is made when the gastric mucosa is actually prolapsed into the duodenal cap.

Case 3. Mrs. A. M., a 54 year old Syrian storekeeper had been extremely nervous for a few months since her husband's death. She cried most of the time while at home, so her children let her return to work in the store which she opened at 5:30 a.m. and closed at 10 p.m. Her chief complaints were dizzy spells and precordial pain with numbness in the left arm. The dizzy spells which occurred several times a day and lasted only a few seconds caused her to stagger but not to fall. The precordial pain was dull aching in character with associated numbness in the left arm. It occurred when she was working or when sitting, but more often during the day than at night. Examination of the heart was negative. Electrocardiogram was within normal limits. On questioning the patient during the review of systems, it was learned that she had no appetite and didn't eat regularly. Several times during the preceding five

months she had vomited after coughing. She frequently was bloated with gas.

Roentgenographic examination on July 21, 1950 revealed a prolapse of the gastric mucosa into the duodenal cap and hiatus hernia. Gastric analysis after Ewald Test meal revealed 60 degrees of free HCl.

This patient was also placed on an ambulatory ulcer regimen, but since her gastrointestinal symptoms were mild she did not follow it.

Since two of these three cases had a hiatus hernia of the stomach in addition to the prolapse of the gastric mucosa, I have wondered if this were more than just a chance mutual occurrence. Dr. J. D. King²⁰ was kind enough to review the cases of herniation of the stomach which he had cross indexed in the 18 months he had been roentgenologist at Crawford Long Hospital. He found, in addition to case 1 of this report, 12 cases of herniation or prolapse of the gastric mucosa into the base of the duodenal cap cross indexed and he remembered others which had been seen but which he considered too minor to index. During the same period of time, 25 cases of hernia of the stomach at the hiatus of the diaphragm were cross indexed. Two of these 25 cases with a hiatus hernia also had prolapse of the gastric mucosa into the duodenal cap. Likewise two of the 12 cases of prolapsed gastric mucosa also had a hiatus hernia. A review of published cases

of prolapsed gastric mucosa revealed only one case with a concurrent hiatus hernia.

Summary

1. Prolapse of redundant gastric mucosa into the duodenal cap is a distinct clinical entity which is being recognized more frequently.
2. The etiology is unknown.
3. No characteristic symptom-complex is present, but symptoms referable to the upper gastrointestinal tract are present in most cases.
4. Diagnosis must be established by roentgenographic examination.
5. Uncomplicated cases should be treated medically with a peptic ulcer-type regimen.
6. Indications for surgery are essentially the same for this condition as for duodenal ulcer.
7. Three cases of prolapse of the gastric mucosa into the duodenal cap are reported. In two of these a hiatus hernia was also present.

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FACIAL ANGIOMAS ASSOCIATED WITH BRAIN CALCIFICATION

JAMES J. CLARK, M.D.

and

ROBERT M. TANKESLEY, M.D.

Atlanta

Facial angioma associated with brain calcification is a relatively rare condition, presenting a striking roentgenologic appearance. Roentgenograms of the skull show clearly the cerebral convolutions as if one were looking at the brain surface grossly.

This pathologic reaction was recently found on x-ray examination of the skull of a 20 year old male. This patient had intermittent attacks of numbness of the entire left side of the body and face, since childhood. These attacks occurred every two or three months as a child, but are less frequent now, occurring every four to six months. In between these major attacks he may have mild disturbances of the same nature. The attack is preceded by headache with nausea, the nausea lasting about three days, but the headache continuing for the duration of the attack. The numbness usually begins in the left leg, but may begin in the left arm and then progresses to involve the entire left side of the body. There is paralysis of the numb area. It is necessary to remain in bed. The attack has the duration of from five to fourteen days, with a seven day average. Convulsions are occasionally present. Consciousness was lost one time. There is persistent weakness of the left side of the body, especially the left arm, between attacks.

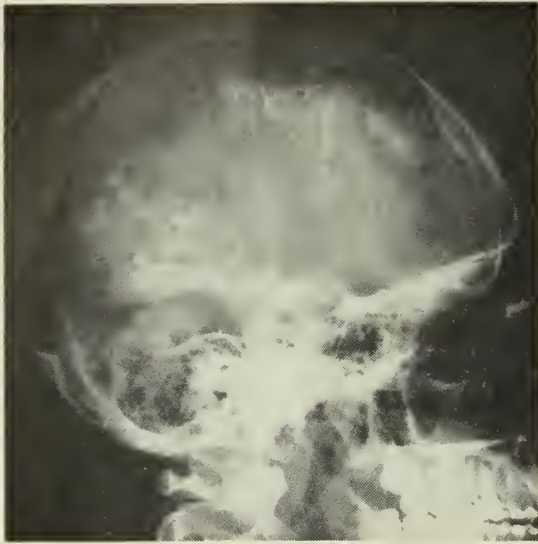


Fig. 1. Lateral film of skull. Note fine granular calcification mentioned in text.



Fig. 2. Note again fine granular calcification in right cerebral hemisphere. (P. A. film).

The patient has noted a retardation in the development of his left extremities.

His physical appearance is somewhat obese. The skin is fine and soft. There are numerous port wine angiomatous markings on the face, mostly on the right. The left extremities are smaller than the right. His physical examination reveals a left homonymous hemianopsia and a persistently positive left Babinski. Physical examination is otherwise essentially negative. Weakness and underdevelopment of the left extremities are present.

X-rays of the skull revealed fine, granular calcium deposits, so minute as to give a homogeneous appearance in the brain cortex of the right occipital and temporal lobes, and also of the right parietal and frontal lobes in their adjacent areas bordering the central sulcus, but to a less extent (Figs. 1 and 2). This right cerebral hemisphere is quite small, either atrophic or aplastic. There is a large space, apparently 1 to 1.5 cm., between the surface of this cerebral hemisphere and the inner table of the skull. The right side of the frontal bone is unusually thick, due to increased thickness of the middle and inner tables of the skull, apparently as a result of the brain aplasia. The

fine granular calcification clearly outlines the gyri and sulci as if the brain were examined grossly. This visualized soft tissue diffused with calcium has a definite brain tissue pattern, and does not represent calcified vessels as occasionally seen in angiomas. The vascular and convolutional markings of the skull are within normal limits. There is no evidence of bone erosion. The sella is of normal size and shape. The skull is symmetrical. The left cerebral hemisphere contains no calcification, and was not visualized. Any lateral shift of the cerebrum from its normal position is not detected.

A survey of the literature reveals only a few reports of this condition. There is a striking similarity in the physical appearance, signs and symptoms in these reported cases. Krabbe¹ (Copenhagen) reports several cases. One of these is apparently the only contribution to the pathologic process involved. This patient had angiomas of the right face and calcification in the right cerebrum. Autopsy revealed an atrophic occipital lobe with fine granules of lime salts deposited in the outer layer of the cortex. The dura and arachnoid were normal. The pia showed no true angioma.

Single cases are reported by Shapiro² and

by Pancoast, Pendergrass and Schaeffer³. Two cases are reported by Lachmann⁴. Two cases are reported by Williams⁵ (St. Mary's Hospital, London).

Greenwald and Koota⁶ surveyed 81 published cases, finding convulsive seizures, generally Jacksonian in type, hemiplegia and mental retardation to be the outstanding symptoms. Thirty four of these cases were studied roentgenologically. X-rays of the skull demonstrated characteristic granular calcification in the brain cortex presenting exactly the shape of the surface of the brain showing distinctly the gyri and sulci. In most cases this appears in the occipital lobe and is usually associated with brain atrophy or aplasia.

Summary

One case of facial angiomas with cerebral calcification is presented. This relatively rare condition presents a characteristic and unique roentgenologic appearance on examination of the skull.

We wish to acknowledge appreciation to Dr. W. H. Benson of Marietta, Ga., for referral and aid in reporting this case.

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MANAGEMENT OF THE AMBULANT ARTHRITIC PATIENT

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The great bulk of arthritic patients seen in an active hospital, clinic and private practice are ambulant. These patients, suffering from rheumatic diseases with various etiologies, present certain similar problems. As long as they are ambulant the objectives of good management would be maintenance of this ambulation through control of pain and

stiffness, retention of functional motion, and protection against deformity.

An effective program must offer simple, readily available and inexpensive measures. A single hormone or a single drug or one physical modality would be the ideal answer. However, in arthritis and rheumatism, we are dealing with a group of diseases, of complex etiologies, varied manifestations and guarded prognoses. These diseases, with rare exceptions, cannot be cured by any specific measure, or one course of treatment; each case requires a program adapted to its individual manifestations. Since recurrence as well as spontaneous remission is not uncommon, these patients need periodic medical supervision. Both the patient and the physician should be aware of the erratic nature of these diseases and should be prepared for possible exacerbations or less than complete recovery.

At one time or another during the course of these various arthritic entities, there will be common symptoms for which treatment will be essentially the same. Despite the marked difference in the pathology of rheumatoid arthritis and osteo-arthritis (degenerative joint disease), there is, in the involved joint segment, a similarity in the problems of pain, stiffness, limitation of motion and muscle atrophy.

Hand: The most frequently encountered localization of rheumatic disease is in the hand. The most common of these are: fibrositis, rheumatoid arthritis and degenerative joint disease.

The patient with *fibrositis*, exhibiting hands with little or no swelling, complains of pain and early morning stiffness. An attentive search will usually reveal tender "myalgic spots" in the base of the thumb or in the interosseus muscles. Needling of the myalgic spots with injection of 1/2 to 1 per cent novocain will often prove effective in the relief of pain. Hot paraffin dips and

local massage are often good supplementary measures.

The symmetrical, painful, spindle-shaped swelling of the proximal interphalangeal joints of the hand is seen most often in rheumatoid arthritis.

Occasionally a patient with a persistently normal sedimentation rate presents a hand in which pain is limited to one or two finger joints with or without swelling, and with negative x-ray findings. This type of arthralgia without joint thickening, limited to fingers of one hand, suggests the possibility of a local joint manifestation secondary to a focal infection frequently discovered in the teeth or tonsils. However, if swelling in the finger joints is present and persists early rheumatoid arthritis is probable. Acute rheumatoid arthritis in hands has a guarded prognosis and the possibility of deformity is to be anticipated. When rheumatoid arthritis of the hand is active and progressive, temporary immobilization of the hand in plaster is indicated. Splinted in a functional position, pain is quickly relieved, muscle spasm subsides and early motion may be possible. Continuous splinting is permissible for short periods of time up to fourteen days; a night splint may be used thereafter for an indefinite period. After removal of the splint, hot paraffin packs are effective in overcoming residual muscle spasm and pain as well as improving circulation.

Heberden's nodes are a manifestation of chronic degenerative joint disease involving the fingers. The distal phalangeal joints show marginal overgrowth of cartilage which eventually calcifies. These nodes are frequently painless and merely constitute a cosmetic defect. However, in the early stages when bleb-like swellings may appear, they are occasionally exquisitely painful. Heberden's nodes have been frequently associated with menopausal vascular changes

and treated with estrogens. Reports of the effectiveness of this treatment are questionable, since this is a self-limited disease. Ethyl chloride spraying of these areas during acute pain has produced a satisfactory analgesia. The patient is taught how to self-spray to the point of cooling with precaution against freezing the area. When acute inflammation has subsided, hot paraffin packs are useful.

Shoulder: The restoration of joint motion in the "frozen shoulder" presents a complex problem. No single measure is effective in the restoration of motion. However, a rewarding routine can be established by use of a novocain block of the suprascapular nerve, followed by cautious stretching of the tight axillary muscles. This procedure should be repeated twice weekly, attempting to gain not more than a 10-15 degree increase in the range of motion at any one sitting.

This office program must be supplemented by intensive hot packings to speed the resorption of exudate and overcome muscle spasm. The patient is to be instructed in the use of hot wet packs, which should be applied intermittently during the interval between office treatments. A suggested schedule for the application of the hot wet packs should include three twenty minute periods in the space of three hours. To retain the motion gained by manipulation, active cooperation on the part of the patient in performing graduated exercises is essential. These consist of Codman's pendulum exercises and the use of the simple overhead pulley.

Cervical Arthritis: Frequently, patients presenting leading symptoms in the shoulder are actually reflecting disease of the spine. Concomitant with shoulder pain may be peripheral symptoms of numbness and tingling in the fingers. If the patient is unfortunate enough to have a fleck of calcium

in the shoulder area, the true source of the underlying pathologic change in the cervical spine causing root irritation can easily be overlooked. Ideally, x-ray examination for shoulder or arm pain should include both cervical-spine and shoulder films. Cervical arthritis with or without nerve root pain is very common. Neck pain and stiffness is most frequently seen in the middle-aged or older patient. On examination rotary and lateral flexion motion may be restricted or painful.

Neck traction with a halter is the most important tool in the management of cervical arthritis. The cervical collar, as ordinarily used, is pointless because it frequently fails in distraction of the lower cervical vertebrae which are most frequently involved. Traction, to be effective, must separate spinal segments. This can be accomplished by the use of a head halter and adequate weights. Both the weights and the periods of time during which the halter is in use should be increased gradually.

At the office initially, with the patient supine, six to eight pounds of traction for a fifteen minute period is adequate. This is followed by diathermy and massage. These measures are supplemented by a traction program at home, the prescribed program varying according to such factors as the patient's symptoms and response. Symptomatic treatment includes hot wet packs and sedatives through the acute stage. As pain subsides, cautious active motion to restore a functional range is introduced.

Lumbar Spine: Degenerative joint disease or osteo-arthritis is probably the most common pathology associated with back ache in the older patient. The obese patient in his fifties, with protruding or pendulous abdomen, complaining of lower back pain in whom roentgen examination reveals a few hypertrophic spurs in the lumbar spine is all too often intimidated by the diagnosis

of "arthritis of the spine." Actually, his problem is basically that of obesity and poor posture, and the true diagnosis is probably that of chronic lumbo-sacral strain and fibrositis. Adequate care includes correction of his abnormal posture, support for the pendulous abdomen, and reduction in weight.

The shortened lumbar muscles are treated with diathermy and deep massage. With relaxation of the contracted spinal muscles, exercises for the atonic abdominal and gluteal muscles are prescribed.

For back muscles in painfully acute spasm, an adequate corset support is far superior to adhesive strapping. The corset will provide necessary immobilization of the lumbo-sacral spine, and should extend from the twelfth dorsal vertebrae to the first sacral segment. Other advantages of the corset over adhesive strapping are the elimination of skin irritation, easy application and removal by the patient enabling administration of local treatment.

Knee: In the lower extremity, the knee joint is the most often involved, the most often seen. The knee cannot be considered as an entity apart from the foot. Therefore, adequate treatment of the knee must be preceded by an examination of the feet to determine the relationship of the distribution of body weight to possible imbalance. Weak or painful feet under stress are often the basis for chronic ligament and joint strain at the knee.

In the acute phase of the painful knee, short periods of bed rest are superior to crutches. Usually the treatment of painful knee consists of the readily available application of heat. Unfortunately, the misuse of heat is a common occurrence. It is a mistake to apply the heat to the anterior aspect of the knee, although it is true that "baking" will have a local and transitory analgesic effect. Excessive "baking" of a swollen knee

will engender a chronic passive congestion, thereby aggravating local disease. Diathermy of the knee here is contraindicated.

Associated with the swollen knee is shortening of the ham strings, atrophy and weakness of the quadriceps femoris. Rationally, heating should be applied to the ham strings to release muscle spasm, and when pain subsides in the knee, progressive exercises of the quadriceps should be instituted to obtain and maintain proper alignment of the joint. Local novocain blocks at the insertions of the ham strings on the tibia are advisable supplementary measures. These insertions should not be overlooked as a possible source of obscure pain of the knee joint.

Gold Salts: Calculating the risk in the use of this heavy metal in rheumatoid arthritis involves precise weighting of the many variables. In the opinion of reputable observers, the hazards of gold therapy outweigh the possible advantages.

Salicylates: Common aspirin is still the most effective analgesic in rheumatic disease. Prescribed and consistently taken in adequate doses to the point of tolerance it relieves pain and releases muscle spasm thus allowing increased motor activity.

Summary

In summary, there is no convincing evidence available that any single hormone, or drug, or physical measure can cure rheumatic or arthritic diseases. Cortisone and ACTH have been heralded as the answer. The general public believes these hormones are effective with all the arthritic diseases, but we know of their effects only in gout and in the collagen group, especially rheumatoid arthritis. No means to date have been devised to prolong the effects of the hormones beyond the period of administration. Furthermore, the supply is so limited that discussion of their practical merits can be deferred until some future date. In the mean-

time, it is vital that we continue to treat our "rheumatic" patients by the best means available using a balanced program of both general and local care, with the objectives, alleviation of pain, prevention of deformity and maintenance of ambulation.

NOTE: Despite the spectacular suppressive effects obtained by the hormones ACTH and Cortisone on certain phases of rheumatic diseases, the basis of treatment must continue to be the simple, readily available and inexpensive measures that will alleviate pain, minimize deformity and maintain ambulation (March 14, 1951).

HEADACHES

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A recent report from a generally unimpeachable source to-wit: "Believe it or not"—indicates that there occurs about an average of one headache per week per person. If medical consultation is sought for as few as one per cent of these each doctor would be asked to treat on the average a bit more than one headache per day. By sheer volume alone, if these deductions are correct this subject is the most important before us.

The listed number of causes of headache are as varied as the number of people listing them. There have been more than 500 causes listed, but the general number of causes range around the figure of Mr. Heinz and Mr. McCarthy, fifty-seven. We must admit that even with these, the great majority of mild non-disabling headaches remain unexplained, though apparently cured by the usual drug store analgesics. Such factors as fatigue, over exertion, worry and alcoholic and food excesses are blamed with no adequately demonstrable pathologic-physiologic basis.

I do not intend to attempt the boresome task of listing types and causes, choosing

only to believe that there are many. I would prefer to have the class differentiated into those that are non-disabling, those that are symptoms of a deeper disorder, and those that are of themselves disabling. The non-disabling type may be dismissed with aspirin, but not before consideration is taken of the fact that fever, brain tumor, meningitis and numerous other pathologic processes which must be recognized could bring about this symptom. With this rather cavalier method of disposing of a very involved subject, the following remarks will pertain to the headaches which are diseases of themselves. I will then proceed to further limit the discussion by similarly disposing of the more or less obvious or fairly easily diagnosable extracranial headaches such as those due to scalp infections, bony discontinuity, otic and ophthalmic disarrangements, and the various neuralgias. Though these are each very interesting and quite involved subjects, they are covered by various specialties and are not in the strictest sense, true internal head pain in and of itself. These are treated accordingly. There remains, then, only the vascular cephalalgias, or migraine, its variants and related cranial vascular disorders. Considering only these, competent authorities generally state that from eight to ten per cent of our population is more or less affected by this syndrome and the problem therefore becomes one of serious proportions.

The fairly recent brilliant investigative studies by Wolff and others have very well outlined the sites of production of internal head pain. These may be quickly summarized by Wolff's statement, "Traction, displacement, distention and inflammation of cranial vascular structures are chiefly responsible for headache." For the limitations described above, these may be considered as the sole cause. Inflammatory causes are generally recognized by fever,

spinal fluid analysis, blood counts, agglutination and similar procedures. For the other vascular cephalalgias, there are no diagnostic procedures available. Physical findings are limited to the finding of occasional transient retinal arteriolar spastic segments in the prodromal stage of a migraine attack, visibly and palpably pulsating temporal arteries in external carotid vascular cephalalgia, and hypertension. Diagnosis rests, then, almost completely on history alone. The great number of historians and the varied historic manifestations of similar vascular phenomena may explain the confusing number of cephalalgia types which have been reported.

From the available evidence, though there may be many causes, the basic pathology of all of these seems to be simply vascular distention. Causes may be allergic, endocrine, hereditary or psychogenic, and in all of these the inciting factor must be diligently searched for. Unfortunately, the specific excitant is rarely found and treatment must be empirical to the extent that it is based on previous experience with similar histories. Therein lies a basic fallacy, for while extremes of the various classified types are and can be recognized, most instances of this syndrome fall into an intermediate type, not truly typical of any form. I humbly suggest, therefore, that treatment of any of these must be directed toward the one accepted pathologic basis, i.e., vascular distention. The various types could be postulated as differing mainly in the site of the vessel affected. This is partially borne out by the available evidence, such as experimental vessel ligation and observations on pharmacologic vessel relaxation in the various states, as done by Wolff and his colleagues.

The apparently pure type described by Horton as being due to histamine sensitization can be cured by so-called specific de-

sensitization. This is not the usual type of allergic desensitization, since the usual types of allergic phenomena supposedly mediated by histamine have not been usually improved by histamine desensitization. Also, the relief induced by graded histamine injections is not usually long lasting unless the injections are continued indefinitely. The good results may, then, be due to a specific pharmacologic action of histamine and not entirely to desensitization. Another drug with comparable vasodilating properties might well accomplish the same result. The hypothesis might be made that histamine, known to cause dilatation of the affected vascular structures, does this with each injection, pain being prevented by the vascular structures becoming accustomed to the increasing degree of dilatation with each succeeding larger dose. It is known that frequent injections must be made and continued, and this may mean that the involved cranial vasculature remains in a more or less constant dilated state. The pain of vascular headaches has been shown to be directly proportional to the amplitude of pulsation in the vessel. If, then, the vessel is already dilated, when the usual stimulus for vessel dilatation comes, such as on increased amount of histamine, the differential is smaller than if the vessel were in its normal or contracted state, the amplitude is much less or non-existent.

The migraine syndrome includes a prodromal stage of vessel contraction, supposedly causing the scotoma and other premonitory symptoms, and the pain component of this syndrome is supposedly due to the sudden relaxation of fatigued vascular channels, with consequent greatly increased volume of pulsations. The premonitory contraction phase would not be as likely to occur nor would the differential pulsation amplitudes be likely to be as great in a pharmacologically dilated vas-

culature. Thus why cannot histamine, or other vasodilators, be used to perpetuate a state of cerebral vascular dilatation to prevent or modify syndromes due to cerebral vascular dilatation. In other words, could a vasodilator used properly and continuously be an effective treatment for all forms of vascular cephalalgia? For some time nicotinic acid has been used for its pharmacologic vasodilating properties in the treatment of headache, and frequently it has been successful. Histamine itself, given intravenously to a patient in the throes of a true histamine headache, will interrupt the headache.

Within the past year or so, whenever a patient who seems to have vascular headaches comes under my care, I have attempted first much less heroic treatment. This includes the usual analgesics, sedation, and the recently available oral mixture of ergotamine and caffeine (Cafergone, Sandoz). If used properly, meaning generally early and in large dosage, most of the cases will be fairly quickly relieved, disability is slight, and preventive treatment is unnecessary. In some others, the additional continuous use of nicotinic acid, 100 milligrams three times a day, provides the necessary relief. Another group, unrelieved by these measures, may in addition be taught the early hypodermic self-administration of sedatives and dihydroergotamine (DHE 45) with acceptable results. The usual adjunctive measures, such as rest, cold to the head, and avoidance of noise and light are employed.

But there remains a number of patients who, though improved, are still disabled by headache. These have, without regard to the location of the involved vessels, been treated by graded histamine injections, and have all so far experienced a degree of improvement in the severity and number of attacks to amply justify the troublesome and

continuous treatment. I make no apology for my lack of statistical analysis of these patients, since this group can easily realize that a small private practice does not provide a statistically significant group, and control studies are fraught with the danger of either overcharging or losing a patient. I simply report this observation for what it is worth and present what seems to be a logical physiologic basis for the observed results.

It is fully realized that this represents only one approach to the problem, and an attack on the end result of many causes and that the approach is largely on empirical and theoretical grounds. It is to be hoped that the underlying causes of this painful end result, such as its relation to hormone excretion and to epilepsy, will be more fully investigated and understood in the future. I believe that the ultimate understanding of these, as well as many other phenomena, awaits elucidation of the hypothalamic-pituitary interrelationships.

Summary

1. The protean nature of this complaint is recognized.
2. Headaches are divided into those which are not disabling or symptomatic, those which are purely symptomatic, and those which are diseases of themselves.
3. An attempt is made to unify the pathologic physiology of the latter group.
4. On this basis, a general plan of treatment for all vascular headaches is suggested.

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PROCTOSCOPY IN THE DIAGNOSIS OF AMEBIASIS

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There is need for greater accuracy in the diagnosis of amebiasis, because early specific therapy with the drugs now available can be expected to result in cure. The diagnosis is missed all too often because stool examination is reported negative. The diagnosis from history and physical examination cannot be differentiated from bacillary dysentery in acute cases or from idiopathic ulcerative colitis in chronic cases. Therefore, it would seem desirable to inspect the diseased rectum directly in an effort to make an accurate differential diagnosis. Proctoscopy is recommended as such an accessory diagnostic procedure. However, every effort must be made to obtain laboratory confirmation by demonstration of the trophozoites of *Endamoeba Histolytica*, as well as routine culture of all stool specimens in such cases, because it is on the laboratory diagnosis that we prefer to depend.

The proctoscopic picture of bacillary dysentery is well described by Lucian A. Smith¹ in a report of 87 carefully studied cases, all of whom presented the characteristic proctoscopic appearance of bacillary dysentery, although positive cultures were obtained in only 48.2 per cent. An excellent description of the lesions of amebic dysentery has been given by Cropper in 1945², and the differential diagnosis of amebic dysentery and chronic ulcerative colitis by proctoscopic examination was reported by Buie³ in 1928. In spite of the specificity of the lesions as outlined by these authors, this important diagnostic procedure is frequently overlooked.

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The examination is simple, and far less uncomfortable than supposed. This is particularly true when the examination is performed with the patient in the knee-chest position, which relaxes his sphincter ani and allows his rectum to balloon open. If he is having frequent loose bowel movements, no preparation will be required, although morphine or a sedative will be beneficial. In cases in which stools are of less frequency, a clear water enema will be adequate to cleanse the rectal mucosa.

This procedure was used in an overseas Army General Hospital, where 632 patients complaining of moderately severe diarrhea or dysentery were proctoscoped in a 3½-month period. Adequate microscopic examinations and cultures of their feces were also performed. A diagnosis of amebiasis was made in 100 of these patients, and it is these cases which aroused our particular interest and which were reported on a previous occasion⁴. During this same period of study a proctoscopic diagnosis of bacillary dysentery was made in 111 patients. Laboratory confirmation of the diagnosis of amebic dysentery could not be made in 23 of the 100 cases, although rectal lesions were visualized that were considered typical of amebiasis. Furthermore, these 23 patients responded symptomatically to routine antiamebic therapy, and repeated proctoscopic examinations revealed that the lesions healed normally. There was even greater difficulty in obtaining laboratory confirmation in cases of bacillary dysentery. In our 111 cases, positive cultures were reported in 51 per cent. These figures for *Shigella* correspond favorably with the positive cultures obtained in 48.2 per cent of the 87 cases reported by Smith¹.

In sharp contrast to the diffusely hyperemic and edematous rectal mucosa forming the background for the lesions of bacillary dysentery, is the normal appearance of the

mucosa intervening between the characteristic lesions of amebic dysentery. For the sake of description, the classification of the rectal lesions may be divided into six phases, although two different types of lesion are often seen at the examination. And when a patient is re-examined early in the course of treatment it is frequently found that another of the six descriptive stages had replaced the picture originally observed. There is no correlation between duration of infection and severity of symptoms on the one hand and the extent of ulcerations. In describing appearances it is impossible to label one or other of them acute or chronic. These descriptive stages and the frequency with which they were encountered follows:

1. The first stage is the appearance of small yellow elevations, with thin hyperemic margins. These lesions have the appearance of very small pustules, or furuncles, and are easily swabbed away, leaving a bleeding pinpoint lesion on the mucosa. This type of lesion was present in 7 per cent of our cases.

2. The second stage is characterized by the appearance of small round patches of a yellow exudative material, which may simulate bullae, or may resemble small snow-flakes lying on an otherwise normal appearing mucosa. There may be five to fifteen of these lesions within the rectal ampulla, and a few may also be seen in the sigmoid. However, they were never encountered in the sigmoid alone. If only a few such lesions are present, there is danger of overlooking them or of mistaking them for loose patches of mucus. The exudate is easily swabbed away leaving a bleeding, granulating appearance to the underlying mucous membrane. The yellow material contained only an occasional pus cell and literally swarmed with trophozoites containing ingested red blood cells. Twenty-eight per cent of our cases had such lesions predominating.

3. The third stage represents a coalescence of the bullous-like lesions, with involvement of a much more extensive surface area of mucous membrane. The exudate is all that is seen and the mucosa intervening between lesions is normal in appearance. The exudate is found to be loosely adherent to the underlying mucous membrane, but is gelatinous in consistency, like thick mucus. It is easily swabbed away, leaving a bleeding, granulating and nodular appearance to the mucous membrane. Such a picture predominated in 14 per cent of our cases.

4. The fourth stage shows more evidence of involvement of the mucous membrane, and less of the exudative response described thus far. The margins of the ulcer take shape, and undermining of the adjacent mucosa is clearly visible. An accumulation of inflammatory tissue occurs, which presents itself as a grayish white covering, known as the "white-cap", over the center of the ulcer. When this is macerated and swabbed away, the granulating red base of the ulcer is revealed below the surface of the overhanging margins. Eleven per cent of our cases were of this variety.

5. The fifth type of lesion has been the most common in our experience, and probably represents a subsiding

state in the history of the ulcers. The most striking characteristic of this stage is the elongated, narrow appearance of the lesions. The first impression is that the normal mucosa has been incised with a sharp knife, and has undergone no healing. The free mucosal edges are separated by a distance no wider than ordinary pencil lead, and frequently they slope downward to rest on the undermined sub-mucosa. These edges are easily macerated by light swabbing, and the gray indurated "white-cap" of the ulcer may be as much as six times the diameter of the original space seen between the free edges of the incised mucous membrane. Such lesions have appeared in 29 per cent of the cases we have seen.

6. The picture that we have seen in the remaining 10 per cent of our cases has been that of the chronic ulcer. It must be appreciated that the sigmoidoscopic picture of this stage varies considerably from our usual understanding of the pathologic picture, with which we are generally familiar. As seen in pathologic section, the chronic ulcer is usually flask-shaped with the mucosa itself being undermined. On sigmoidoscopic examination, only the superficial layer is visualized. This varies with the ulcer and upon the amount of exudate collected within the submucous portion of the ulcer. Thus it may be represented by multiple nodules with small sinuses at their apices or there may be a larger necrotic mass of tissue lying depressed below the level of the adjacent normal mucosa.

In describing the picture of bacillary dysentery, Smith¹ states that there is a diffuse velvety hyperemia and edema, a generally very angry-looking mucosa forming the background. Punctate, flame-shaped or ecchymotic hemorrhages are visible either in the mucosa or beneath it. Studded through the mucosal surface in this acute phase there may be miliary mucosal abscesses of pin-point or pin-head size, which are creamy in color, slightly elevated, and probably represent localized accumulations of leukocytes. An early picture in the more acutely severe cases is a diffuse superficial necrosis of the mucosa, with dissolution of the normally smooth surface and the formation of a pseudomembrane which clings closely. This may be wiped free, leaving a red to purple raw mucosal surface which may be friable enough to bleed freely, giving frank blood mixed with pus or mucus in the lumen of the bowel.

The subsiding phase of bacillary dysentery is characterized by an early disappearance of the edema and hyperemia, followed by the ulcers disappearing, and, in our experience, the lesion to persist the longest is usually the flame-shaped hemorrhage, which

may be present a week or so after all symptoms have subsided. Small granulations may be barely visible, and have the appearance of slightly elevated pink lesions, similar to lymphoid tissue in a mild pharyngitis.

The description of idiopathic ulcerative colitis as described by Buie³ need not be repeated. It might be stated that, while early idiopathic ulcerative colitis is easily confused with bacillary dysentery, it bears no resemblance to the characteristic picture of amebic colitis. The simplest and most common differential point is the condition of the mucosa between the ulcers—normal in amebic, diseased in idiopathic ulcerative colitis.

Because of the high incidence of unsuspected amebiasis and the need for greater accuracy in its diagnosis, more general use of the proctoscope is recommended.

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AUREOMYCIN AND ANTIHISTAMINES IN THE TREATMENT OF THE COMMON COLD

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and

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The common cold is a mild upper respiratory disease, the true nature of which is still somewhat obscure. The consensus at

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present seems to be that it is caused by a filtrable virus which sets up an allergic state in the nose and throat rendering these regions vulnerable to the invasion of bacteria that are normally there. If this concept is true, then a drug that would inhibit the growth of the virus or secondary bacteria or both should be able to abort a cold in its early stages or cure a cold any time during its course. Since aureomycin has been demonstrated to be the most versatile drug against a wide variety of micro-organisms and some rickettsias and viruses,^{1 3} it was chosen for a trial. Antihistaminic drugs which have recently received many favorable reports,^{4 11} except in one instance¹², were included in the present study for the purpose of comparison as well as added evaluation.

Method of Study

One hundred cases of common cold were carefully selected, arbitrarily divided into five equal groups and treated orally according to the following regimens:

Groups	Medicine	Single Dose	Total Dose
I	Aureomycin	500 mg.	t.i.d. for 2 days
II	Tagathen	25 mg.	t.i.d. for 2 days
III	Anahist	50 mg.	q.i.d. for 2 days
IV	(Aureomycin Tagathen)	500 mg. 25 mg.	t.i.d. for 2 days
V	Placebo		t.i.d. for 2 days

Tagathen, or chlorethen citrate, is an antihistaminic drug manufactured by Lederle Laboratories. Anahist, or neohetramine, (group III), an antihistamine of reported value against colds, was used to check on the efficacy of tagathen (group II); both of these were used as positive controls while the placebo (group V) was used as a negative control for aureomycin (group I). Aureomycin and tagathen were combined (group IV) with the hope of obtaining a compound that will possess the beneficial effects of both. The different types of medicine and the placebo were prepared in identical yellow capsules so that they were indistinguishable in appearance.

The clinical material included in this study was almost exclusively derived from the student body of the Medical College of Georgia. Besides explaining the purpose of this research, the prospective patients were told the typical clinical course of the common cold¹³. Only those patients with a more or less typical onset of colds of from 4 to 48 hours duration were to come for treatment. Patients with colds older than 48 hours were accepted only if they had a past history of consistently prolonged course or if the present illness was unusually prolonged with no signs of impending recovery. Chronic victims with a history of hay fever were rejected. Patients with a history of chronic sinusitis but without detectable clinical signs at the time of the examination were accepted on a tentative basis. When definitive symptoms of sinusitis developed in follow-up studies, they were excluded.

Nose and throat cultures were taken with separate swabs and each streaked on a fresh blood agar plate. The plates were immediately placed in an incubator, to be examined 24 hours later. The patient was then given the medicine with proper directions and warnings against possible drug reactions. Extreme care was exercised against prejudices in giving the different types of medicine. Patients were assigned to group I through group V and over and over again according to the order in which they came. The patient was asked to return after the prescribed amount of medicine had been taken, i.e. two days later. During the second visit, the clinical progress, drug reactions, etc. were noted. Gross and bacteriologic examinations of the nose and the throat were again made. If the patient had completely recovered, the case was closed. But if symptoms persisted, another check up in two days was made.

Bacteriologic Studies. After 24 hours of incubation the blood agar plates were ex-

amined for the predominating types of colonies. The type of colony and morphology of stained bacteria were principal criteria used for their identification. All predominating types of colonies picked from pretreatment cultures were also tested for aureomycin sensitivities by streaking their broth subcultures on blood agar plates impregnated with aureomycin.

Results

Since no one is able to mark off a distinctive clinical unit for the common cold¹⁴ and since it is mild, self-terminating and short lived, the evaluation of the effectiveness of any therapeutic agent on this disease is difficult. Any drug that is expected to be acceptable to the public should meet certain standards. It was, therefore, postulated that an acceptable cold remedy should be simple and convenient to take. It is preferable that it can be taken orally and that it does not require frequent or prolonged administration. It should be effective when taken any time during the course of disease, and its action should be prompt. With these standards in mind, the results of the treatment are classified as excellent, good, doubtful, or ineffective according to whether complete recovery took place in 24 hours, 25 to 48 hours, 49 to 96 hours, or more than 96 hours after the institution of medication (table 1).

ures in group I; 3 (15 per cent) against 17 in group II; 3 (15 per cent) against 17 in group III; 5 (25 per cent) against 15 in group IV; and 1 (5 per cent) against 19 in group V. If the number of successful cases in the group given placebos (group V) were subtracted from the number of successful cases in each of the four groups given medicine, the net numbers of successful cases due to the medication for groups I, II, III, and IV would be 5 (25 per cent); 2 (10 per cent); 2 (10 per cent); and 4 (20 per cent), respectively.

Toxicities occurred in 28 of the 80 patients who were medicated (35 per cent), while none occurred in the 20 control cases. Of the treated groups, most reactions were found in the groups treated with aureomycin and its combination with tagathen (groups I and IV). These consisted of diarrhea, nausea, drowsiness, dizziness and pruritus ani or vulvi. Among the patients treated with tagathen (group II), drowsiness and headache were the more common complaints, while those treated with anahist (group III) experienced least toxic reactions.

Twelve per cent of these patients had either one or two of the following complications: sinusitis, acute bronchitis, swelling of cervical lymph nodes, and otitis media. The highest incident occurred in the placebo

TABLE 1
Results of Treatment of Colds in 100 Patients

Complete Recovery in Hours After First Dose	I	II	III	IV	V
13-24 hr.	3 (15%)	2 (10%)	1 (5%)	2 (10%)	1 (5%)
25-48 hr.	3 (15%)	1 (5%)	2 (10%)	3 (15%)	0 (0%)
49-96 hr.	6 (30%)	5 (25%)	5 (25%)	3 (15%)	4 (20%)
96 hr.	8 (40%)	12 (60%)	12 (60%)	12 (60%)	15 (75%)

If those who had excellent and good results were grouped as successful and those who had doubtful or ineffective results were grouped as failures, then there were 6 (30 per cent) successful cases against 14 fail-

group. Acute bronchitis was not encountered in the groups treated with aureomycin or its combination with tagathen, although it occurred fairly frequently in other groups.

Bacteriologic Studies. The predominat-

ing nasal floras were comparatively fewer than the predominating pharyngeal floras. The pretreatment nasal floras consisted mainly of staphylococci, streptococci and Micrococci tetragenes, while those of the throat consisted of these and Neisseria and Hemophilus influenzae. The general changes after treatment were the decrease in staphylococci, streptococci and Hemophilus influenzae. However, these changes took place in failures as well as successful cases, indicating that the bacterial floras cannot be depended on for determining the condition of a cold.

A total of 419 aureomycin sensitivity tests were performed on these predominating bacteria. With the exception of three strains of Proteus species, all bacteria were inhibited by 10 micrograms or less of aureomycin per cc. of the blood agar medium. Over 90 per cent were inhibited by 0.1 to 1 microgram. Six strains of Neisseria and one strain of coliform bacillus were sensitive to 1 microgram or less of aureomycin.

Discussion

Since a great part of the present research required and had to require the patient's opinion, the class of people constituting the patient became important. For this reason as well as for circumstantial convenience, this study was more or less limited to the medical students; children and non-intellectual class of people were avoided.

The diagnosis of the common cold, especially during the early stages, is often difficult even in the hands of most skillful physicians. In fact, this is the disease in which a patient's opinion is of considerable value. The otorhinolaryngologists are said to be unable to make a diagnosis based on local examinations alone¹⁵. Therefore, in making a diagnosis, the following three sets of criteria were depended on: First, the patient's opinion which was formed by his or her past experience and the knowledge of

the typical clinical course of a cold; second, the history and symptoms of the present illness as told by the patient; third, examinations of the nose and throat, chiefly for the exclusion of other pathologic conditions. In the absence of a set of distinctive symptoms and reliable diagnostic tests, it was thought advisable that all available information should be gathered and carefully analyzed in order to keep diagnostic errors at a minimum.

Antihistamines. In this study, two preparations of antihistamines, namely tagathen (group II) and anahist (group III), were used. The total number of patients treated with these two drugs, besides the combination of tagathen with aureomycin (group IV), was forty. Both antihistamines showed some beneficial effects in common cold, and both were more effective when given early in the course of the disease. The best effect was achieved when the duration of cold was no longer than 12 hours. The net percentage of success in each group was ten—which is a small success, but definite in view of the extreme care exercised in selecting patients and rigid rules used for the criteria of success. These figures are not inconsistent with Brewster's reports^{6, 7} if his results are subjected to similar scrutiny.

Therefore, it is our belief that antihistamines do have some beneficial effects on the common cold but they have their limitations. They are somewhat useful in early colds, useless in colds of more than two days duration, and they should be taken with proper precautions against possible accidents however remote these may be. If one accepts these facts and expects no more than what this group of medicine actually merits, then there should be no overestimation nor should there be great disappointment. Until a real cure for colds is discovered, antihistamines have their value as a palliative treatment.

Aureomycin. Both aureomycin (group I) and its combination with tagathen (group IV) were more effective against the common cold than the two antihistamines (groups II, III). The net percentage of success was from 20 to 25, or from two to two and a half times that of either of the two antihistamines. Since the combination of aureomycin and tagathen did not yield better results, the action of these two types of medicine is apparently neither synergistic nor additive. The effect obtained in group IV was probably due to its aureomycin component.

Since aureomycin is an antibiotic, its effect on the common cold is probably due to its antimicrobial action. It is difficult to say at this time whether this action is on the virus, on the secondary bacteria, or on both. The aureomycin sensitivity tests indicate that aureomycin is highly bacteriostatic against the predominating bacteria in the nose and throat of these patients. The fact that the posttreatment bacterial floras did not show any changes reflecting the action of aureomycin was probably due to deterioration or low concentration of this antibiotic on the surface of these regions.

Because of its wide range of antibacterial activities, aureomycin is also helpful in preventing or treating the complications of colds, especially bronchitis. In all the 40 patients treated with aureomycin, not a single case developed bronchitis, although this complication occurred in the other groups. Aureomycin is also highly effective against laryngitis. The voice of the patients usually returned in 24 to 48 hours under aureomycin therapy.

Since aureomycin is from two to two and a half times as effective as antihistamines against colds and since the latter are claimed as excelling all previously used cold remedies,^{9, 10} aureomycin may be regarded as the most effective cold remedy at present.

Although the net percentage of cure with aureomycin is still far from the goal, this finding does indicate the possibilities of treating colds with antimicrobial agents.

Summary and Conclusions

A total of one hundred patients suffering from the common cold were carefully selected and arbitrarily divided into five equal groups. The first four groups were treated with aureomycin, tagathen (chloroethen citrate), anahist (thonzylamine hydrochloride), and aureomycin and tagathen combined, respectively, while the fifth group was given placebos to serve as controls.

Antihistamines are found to be helpful when taken early in the course of a cold and that their effects decrease to practically nil when a cold is older than 48 hours. In rigid terms, the percentage of success for each of these two antihistamines when taken within 48 hours of onset is ten, which is not inconsistent with the reports of other investigators if their results are subjected to scrutiny similar to that employed in this study.

Aureomycin is from two to two and a half times as effective as antihistamines against colds. Its action is not clearly understood, but is believed to be antiviral and/or antibacterial. Aureomycin sensitivity tests of all predominating bacteria found in the nose and throat of these one hundred patients indicate that these bacteria are highly susceptible to aureomycin. The greatest drawback of aureomycin therapy lies in its production of gastrointestinal disturbance in a big proportion of cases.

Since the net percentages of cure are low, neither antihistamines nor aureomycin can be regarded as satisfactory treatment for the common cold. However, the finding of the effect of aureomycin against colds represents a new and fundamental way of approach in cold therapy, i. e., attacking colds at the cause. With the incessant and rapid progress in chemotherapy, it is be-

lieved that a real cure for colds may be found in the future, be it a drug or a drug combination. Any cold cure which is expected to meet the public approval and to withstand the test of time should possess the following features: it should be convenient to take, preferably an oral medicine; its action should be sure and prompt; it should be effective when taken at any time during the course of a cold. These are the standards employed in evaluating the results of this study and they should constitute the goal that the medical profession strive to attain. Only after such a remedy is obtained can this disease be considered as having been conquered.

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HEALTHGRAM

Mass case finding in hospitals can be effective if applied to two groups—admissions and personnel. It is known that our medical and nursing personnel are only too often exposed to active cases of unknown tuberculosis. This is especially hazardous in the general hospital since the prophylactic nursing techniques usually fall short of those required in a communicable disease institution. The incidence of tuberculosis among doctors and nurses is already several times that of comparable age groups in the general populations, and they should not be needlessly exposed when the method of detection is so readily available. Hospital Council of Greater New York and New York Tuberc. & Health A.—1950.

THE PROBLEM OF GOUT

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One of the most serious problems in medical practice today is that of arthritis. The pain and suffering endured by these patients, the crippling deformities to be endured, the hopelessness and the frequent invalidism, makes the problem of arthritis well worth our consideration.

We are going to discuss the problem of gout, for 5 per cent, or one in every 20 patients that you see with arthritis, is suffering with gout. How many times have you made that diagnosis in the past five years?

Gout is probably one of the most neglected disease syndromes in the field of American medicine. Recent graduates in medicine say that they have been taught that they will probably never see a case of gout in a life time of practice. Five per cent of all arthritics seen at the Mayo Clinic were suffering with gout. In a series of 100 cases of gout, reported by Hench, approximately 15 years elapsed after the first attack, before a correct diagnosis was made. The malady is encountered all too frequently by general practitioners, surgeons and internists, and even in the classical form it is not identified as such. Very often the patient suggests the diagnosis, or the physician or some friend jestingly suggests the gout. After the diagnosis is properly made it is not usual for effective treatment to be prescribed. Gouty individuals will continue to suffer until the problem is immediately considered by every physician when he sees a case of arthritis, and he is informed concerning the effective management of gout.

Gout is one of the oldest diseases known to man. Hippocrates left us an excellent description of the malady. The clinical man-

ifestations of the disease were well known to the Greek and Roman physicians. Aretaeus of Cappadocia observed that during a remission, a gouty individual was capable of winning the Olympic games. In the classical "Tractatus de Podagra et Hydropse" published in 1683, Thomas Sydenham, who was afflicted with gout most of his life, attempted to differentiate gout from other diseases of the joints. One of the most useful drugs in the management of the condition, colchicum or colchicine has been in use for 1500 years. William Cadogan in "A Dissertation on Gout" published in 1771 says, "The gout is so common a disease, that there is scarcely a man in the world, whether he has had it or not, but thinks he knows perfectly what it is". Uric acid was found to be a constituent of kidney stones by Scheele, 1776, and in 1797, Wollaston discovered the presence of uric acid in gouty tophi. Huber in 1896 published a reproduction of an x-ray plate which illustrated the lesions produced by gout. Emil Fischer in 1907 determined the chemical structure of uric acid and its relation to the purines. Gout was not regarded seriously by American physicians until about 1935. Since that time such workers as Bauer, Haden, Talbott, Wright, Cecil, Hench and Freyberg have made important contributions to our understanding of the disease.

Gout is considered to be a disease of metabolism. Every gouty individual at times has hyperuricemia. There is an hereditary factor, for numerous family studies of gouty patients reveal a high blood uric acid in large percentage. There is also an allergic factor, for Harkavy has reported three cases, all of whom in the course of specific antigenic treatment developed acute attacks of gout from doses of pollen and other specific antigens.

Ergot preparations, liver extract and other drugs have been proven to initiate an

acute attack. Gout has been associated with lead poisoning. Rapid weight reduction has apparently caused acute flare-ups of the disease. Operative procedures frequently precipitate an acute attack of gout.

Gout attacks all races and both sexes, although most reports show that 95 per cent are men, and only 5 per cent women. It does attack children and younger individuals, but more frequently it starts in the fourth or fifth decades. Usually, but not always, the individual attacked is or has been obese.

In spite of all of these known factors, we have to say that gout is a disease of unknown origin, certainly a metabolic disease with hereditary factors.

In about 50 per cent gout starts in the classical form, or as it is otherwise termed podagra. The onset is acute, with the patient awakening in the middle of the night with severe burning, gnawing pain in the great toe or first metatarso-phalangeal joint. There is apprehension and fear of any movement or disturbance. The temperature may be normal or go to 103 degrees F. The joint is swollen, red or bluish red, the skin tense and the veins distended. In most patients, an early attack will subside spontaneously in from 3 to 10 days, the pain disappearing as rapidly as it came, the swelling rapidly recedes, and the skin usually desquamates. At the termination of an early attack the patient is apparently as well as he has ever been. In other gout patients, the original attack may be in the ankle, knee, hand, wrist, elbow, or other joints. The early attacks are almost always monarticular. It may be months or even years before other attacks occur; usually they do occur and with increasing frequency. More and more joints become involved and with varying periods of time chronic arthritis develops. The deformity may progress to total disability.

The diagnosis of classical gout, or podagra, should not be difficult. The sudden

acute onset, the swollen, hot, red or bluish red, first metatarso-phalangeal joint, the distended veins, and fear of movement, should make the attending physician suspect acute gout.

The diagnosis of chronic gout is usually not so easy. Other joints may be involved in early attacks. The patient may not consult the physician until later stages and chronic arthritis has developed. A careful history is the most important clue to the diagnosis. The history of familial arthritis, the periodic acute attacks with increasing frequency; (the periodic attacks of pain are more severe than in any other type of arthritis). In young individuals renal stones associated with joint involvement usually mean gout. Following the acute periodic attacks, the gradual onset of chronic arthritis makes it imperative that gout be ruled out as the cause. In the later stages, although they may occur early, uric acid deposits or tophi on the ears or about the joints are pathognomonic of the disease.

If tophi are found, the diagnosis may be proven immediately by excision and finding the urate crystals by microscopic examination.

In the acute attack, the serum uric acid may be normal, that is less than 5 mg. per cent, or it may be elevated as much as 10 mg. per cent. It may be elevated between attacks and drop to normal with the acute onset. By repeat checking it will be found elevated at sometime in the course of the disease. It is usually elevated when the chronic arthritic changes have occurred.

The first x-ray evidence of bony changes in gout occurs after several acute attacks, and the chronic stage has started. The earliest change found is the appearance of a zone of osteoporosis on the medial aspect of the base of the first metatarsal bone and the first phalanx.

As the gouty process becomes more ex-

tensive this zone becomes frankly cystic. The bony structure is completely obliterated and shows a punched out appearance.

The next stage shows a narrowing of the joint spaces as a result of the obliteration of cartilage. The joint may show marginal hypertrophy, semicircular and circular translucencies.

Because the obliteration of the cartilage is uneven the surfaces of the joints may become very irregular, and marginal hypertrophic changes appear. Tophaceous deposits in the ends of bone may cause a marked destruction of the joint.

Extensive destruction of the joint occurs and numerous areas of cystic caries may produce a honey-comb effect. These lesions may cause wide spread obliteration of the epiphyses and joints. Entire joints may disappear leaving bony stumps projecting into a tophaceous mass.

An occasional result of a large urate deposit in the epiphyseal region is expansion of the cortex. This may produce an appearance in the x-ray resembling the picture of certain bone tumors; for example, giant cell tumors or osteogenic sarcoma.

Tophi are not particularly radiopaque, and as a result larger tophaceous masses cast only evenly dense x-ray shadows, the opacity of which will depend upon the size of the tophi. Small tophi cast no shadows at all.

The pathology of acute gout and the vascular complications are unknown. Urate deposits are without doubt the cause of gouty arthritis and gouty nephritis. The gouty granuloma, a unique and specific lesion, is characteristically present in tissues affected by gout. The gouty granuloma consists of (a) a central zone in which are deposited crystalline urates, cholesterol and necrotic tissue debris; (b) surrounding this central zone an inflammatory region of varying cellularity; (c) beyond this, a stroma or sup-

porting tissue of varying fibrous density. Giant "urophages", reticulo-endothelial cells, containing many nuclei in a single protoplasmic agglomeration are present. These cells ingest bundles of urate crystals. The gouty granuloma is frequently referred to as a gouty "tubercle". The synovial membrane reacts to the granuloma or tubercle by thickening and pannus formation. This differs from rheumatoid and tuberculous arthritis, because it is destructively encrusted with urate crystals. The inner surface of the joint may appear to have been smeared with coarse white paint. Gouty tubercles form the destructive lesions in the osseous tissues. They appear in such different sites as the cartilages of the ear, the olecranon bursae, the kidney parenchyma, the myocardium, the heart valves and even in the tongue.

The complications of gout are degenerative vascular disease, gouty nephritis and renal colic from urate gravel. Urate gravel and stones are present in from 10 to 30 per cent of cases. Always suspect gout in cases of acute or chronic arthritis with renal stones or nephritis. We must not forget that rheumatoid arthritis and osteo-arthritis may occur in a gouty individual.

The treatment of an acute attack of gout, after recognition, is usually a simple matter. Very few articular diseases will respond so promptly.

The affected part should be put at complete rest. Hot or cold wet compresses give some measure of relief. If the pain is too severe morphine or codeine should be used. Colchicine gr. 1/100 is given every hour until the pain has disappeared or nausea or diarrhoea develops. It is our most beneficial drug (It has been in use for 1500 years). Salicylates, either sodium salicylate or aspirin in 25 grain doses every 4 hours are important, by relieving the pain and aiding in the elimination of uric

acid. Sodium bicarbonate and large quantities of fluids should be used. In most acute attacks the above measures will be effective. In the occasional stubborn case, cinchophen grains $7\frac{1}{2}$ four times daily may be used. Cinchophen is a more powerful uric acid eliminant than the salicylates. (However cinchophen is a dangerous drug that has caused fatal acute yellow atrophy). If the acute attack has not subsided within 3 to 4 days with the above, then the patient should be hospitalized for treatment with ACTH and colchicine. ACTH is given in 50 mg. doses every 4 hours, together with colchicine grains 1/100 every hour. Usually the acute attack will subside with one or two 50 mg. doses of ACTH. Most authorities agree with the above or similar treatment for acute gout.

Concerning the interval treatment or management between attacks there is some disagreement. A few investigators feel that between acute attacks moderate dietary restriction and avoiding the use of alcohol is all the treatment indicated. The majority, however, feel that the gouty state can be combatted and the development of deforming arthritis checked by a definite treatment regimen.

The interval treatment should consist of:

- (1) Moderate living, with adequate rest.
- (2) A low purine, low fat diet.
- (3) Colchicine grain 1/100 daily or 3 times daily, three days weekly.
- (4) Salicylates with alkali grains 25 three times daily, 3 days per week.
- (5) Abstinence from alcoholic beverages.

It has been determined that with such a schedule of interval treatment, the number and severity of attacks are drastically reduced, and the development of arthritic changes are prevented or at least develop much more slowly.

The above interval treatment is also useful after gouty arthritis has developed. In addition, heat and moderate massage with

active and passive joint activity should be used.

CASE REPORTS

Mr. L. T., white male, aged 59, moderately obese. Admitted to the hospital June 29, 1950.

He complained of pain, redness, and swelling of the left metatarso-phalangeal joint of 5 weeks duration. During that time he had been totally disabled, and away from work. He had been under treatment for a streptococcal infection of the foot, with heat and sulfonamides.

The patient gave a history of a similar attack in the right foot with four months disability two years before. Since that time he had been perfectly well until present onset.

On examination the left metatarso-phalangeal joint was greatly swollen, skin tense, slick, and red. The same joint on the right foot was enlarged, but not painful. Pulse, temperature and blood pressure were normal. Blood counts and urine were normal. The glucose tolerance curve was within normal limits. The PSP was 51 per cent in 1 hr., NPN 40; cholesterol 128, and uric acid 8.75. EKG showed a minimal depression of the S-T segments in the standard leads; otherwise normal.

X-ray of feet showed definite destruction of the articular margins of the metatarso-phalangeal joint of the right great toe on its mesial aspect. This is a change secondary to a rather long standing gout. There is no appreciable change in the same joint on the left foot. Chest film showed no pathologic changes of the heart or lungs.

The patient was given colchicine grains 1/100 every hour until nauseated. He was also given aspirin grains 25 with sodium bicarbonate grains 30 three times daily.

Within 24 hours the joint was comfortable and the patient weightbearing. Within 48 hours the swelling had disappeared. The patient is now on interval treatment and there has been no recurrence.

Mrs. D. V. K., white female, aged 53, farmer's wife, was seen May 28, 1949. She complained of soreness and stiffness in hands in early morning. There was also tenderness in the cervical spine.

She gave a history of having an acute arthritis of the hands in 1932, following teeth extraction, that lasted several weeks. She was given "shots" at that time. Since then she has noted occasional stiffness and mild joint soreness, but not severe enough to consult a physician.

On examination: Blood counts, sedimentation rate, and urinalysis were within normal limits. Temperature 98.2F; pulse 64; B.P. 116/70; weight 150. The metacarpo-phalangeal joints were enlarged and deformed, particularly those of the index fingers.

The metatarso-phalangeal joints of both feet were enlarged, but asymptomatic. A tentative diagnosis of rheumatoid arthritis was made.

She was treated routinely with vitamins, salicylates and physical measures, with some improvement.

In November 1949, she started having repeated acute attacks with no apparent response to treatment. By April 1950 the deformity had increased and the pain was so severe she could not close her left hand. She was unable to milk or to wash dishes. She also was having pain and soreness in both feet and ankles, as well as stiffness in the knees.

On April 22, 1950 the uric acid was 4.2 mg. X-ray of hands showed marked narrowing of the interphalangeal joint spaces of all the fingers, especially marked in the fifth finger of both hands. There was considerable destruction of the joint between the proximal phalanx and the metacarpal of the second finger of the left hand. The appearance of this joint is typical of longstanding gout.

The patient was given colchicine grains 1/100 every hour to the point of nausea. At the same time she

was given salicylates and alkali. Within 24 hours there was a remarkable improvement in the pain and stiffness. She was then put on interval treatment; low purine diet, colchicine grains 1/100 t.i.d. 3 days per week and aspirin grains 25 p.c., 3 days per week. She had considerable improvement and was able to do all of her work except milking.

On October 2, 1950 because of continued joint soreness she was hospitalized. She was given ACTH 20 mg. with colchicine grains 2/100 q6h for two days. There was marked relief from pain.

At present she is taking a low purine diet, colchicine grain 1/100 t.i.d., aspirin and alkalis. She is much improved.

Mr. J. N., aged 53, business man, moderate obesity, was seen in office October 2, 1950. Came in with right shoe cut out over bunion joint.

Complaints: pain, swelling, redness of right bunion joint.

Patient stated he took highballs every evening and occasionally too many.

First attack of pain and swelling of right great toe, lasting 10 days, in May 1950. An acute recurrence in September and again 1½ weeks later. He had been told by his physician that if he were a rich man it could be called gout.

On examination, the right metatarso-phalangeal joint was enlarged. Two gouty tophi were present on the right ear. Diagnosis: acute gout.

Although the patient had suggestive evidence of a renal stone and digestive symptoms suggesting a peptic ulcer, he refused hospitalization and further study.

Colchicine and a low purine diet were prescribed.

Summary

Gout is a metabolic disease of unknown origin, but having hereditary and allergic factors.

Gout accounts for 5 per cent of all arthritis in this country.

The disease is in most cases controllable with present available treatment.

Three case histories have been presented.

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MANAGEMENT OF PINK EYE

W. P. RHYNE, M.D.

Albany

"Pink eye", or conjunctivitis activated by the Koch-Weeks bacillus, has received more different types of treatment in this part of the country than any other eye affliction. Affliction is used

instead of infection to stress the importance of this condition. Many families and children have the whole summer ruined because one member has pink eye and can't get out in the sunshine or won't open the eyes to see how to get about. The pain of this condition is moderate to severe, and the patients get a sensation of relief by keeping the eyes closed. They are so intent upon keeping the eyes closed that it requires the help of several people to get a fleeting glimpse of the cornea and conjunctiva of certain individuals, and restraint is almost always required in treating cases of this kind.

Textbooks and most eye men give zinc sulfate as a specific for this infection. Maybe at one time zinc sulfate would handle all cases, but the attenuated form of the disease present in this part of the country almost requires the rod to be hammered open and soaked in caustic. Returning from the Army in late 1945, I found quite an epidemic in progress in this area. Treatment ranged from applications of NaCl, $MgSO_4$, and all the proprietary remedies up to and including massive I.M. doses of penicillin. Penicillin was used as drops and ointment in various strengths, but was not particularly efficacious as the best remedy. One per cent silver nitrate, homatropine, and a combination of zinc, pontocain, and $MgSO_4$ drops, and sulfadiazine by mouth worked better than any other combination at that time. When the "pink eye" season began in the spring of 1946 a solution of streptomycin 1:100 was tried in conjunction with $AgNO_3$ and sulfadiazine. This strength was varied from time to time, increased and decreased experimentally to determine the most effective solution, but the original proportions have been most effective. It works with or without the silver and sulfadiazine, but the latter two seem to speed the cure somewhat.

It was anticipated to use this solution on a thousand cases and make a report, but with the drops from one family being passed on to another, I'm sure it has been tried in many more cases at present. One can be assured that a drug is effective if it is adopted by the general men and druggists. Just how the solution attacks the "red hot rod" of the Koch-Weeks bacillus is not apparent to the writer, but the disease process is eliminated, which in the end is by far the most important. One gram of Dihydro-Streptomycin to 100 cc. normal saline seems to be the solution of choice as drops—several drops in the eyes every 3 or 4 hours.

URGE MORE EXPENDITURES FOR PREVENTION OF BLINDNESS

In 1940 more than \$125,000,000 in tax and private funds was spent for care and services to the blind. Money available for research in the blinding eye diseases for the same year was less than \$1,000,000.

Less than \$500,000 was spent for organized prevention services.

This striking contrast between the funds used for aid to the blind and those used for the purpose of prevention and research is brought out by Drs. Walter B. Lancaster, Boston, and Franklin M. Foote, New York, in the January 6 *Journal of the American Medical Association*.

Dr. Lancaster is an ophthalmologist, a specialist in diseases of the eye. Dr. Foote is associated with the National Society for Prevention of Blindness, New York.

"We should not reduce activities for those already blind," the doctors pointed out, "but by increasing what we are doing now to enable persons to keep their sight we can gradually reduce the number of unnecessarily blind."

The report estimated that about 22,000 people each year have their vision reduced to one-tenth of normal vision.

Blindness is a major public health problem, the doctors said, not merely because of its incidence but also because the blind man or woman lives on for many years often partly or wholly dependent on others.

Based on information covering 3,905 children in schools and classes for the blind and 46,537 adults receiving aid to the blind, it is estimated that blindness in all ages is due to infectious diseases in 22.5 per cent of the cases, to injury in 9.3 per cent, poisonings in 0.6 per cent, tumors in 0.9 per cent, general diseases in 5.5 per cent, prenatal origin in 12.2 per cent and causes unknown to science in 29.9 per cent. The remainder are of undetermined or unspecified origin.

Of the blindness resulting from injuries, about half are of occupational origin. The others are due to accidents at play or in the home.

From 1936 to 1943 a 25 per cent decrease in blindness among children in schools for the blind as a result of eye injuries was noted. This encouraging drop was attributed by the doctors as partly due to "wise legislation which has been adopted in 10 states to regulate the use of air rifles by children and in 29 states to control the sale of fireworks."

The doctors cited a recent study of accidents among school children over a period of 17 years which showed that approximately 88,000 eye injuries requiring medical attention occur each year. In addition about 1,000 children lose the sight of at least one eye.

"In this group over half of the eye injuries occur during unsupervised play," the doctors indicated, adding that boys have three times as many eye injuries as girls.

They predicted that glaucoma, a disease which causes about one-eighth of all blindness in this country, is likely to be an increasing problem as public health measures increase the span of life. "Glaucoma results in hardening of the eye and occurs more frequently in persons over 45 years of age, according to the report.

"Both fundamental laboratory research and clinical research in the blinding eye diseases are urgently needed for progress in prevention," Drs. Lancaster and Foote stressed.

Among children in schools for the blind, they pointed out, 61 per cent are blind from causes of prenatal origin. At least 16 per cent of blind children have hereditary conditions.

In the future, public education is essential, the doctors said, to help in eliminating the cause of blindness, adding:

"Public education is necessary to make the average man realize that even an apparently minor symptom may be the only warning he will have of a serious eye condition."

The photostatic copy of the letter written to a Confederate doctor, S. H. Stout, Medical Director of Hospitals, Army of Tennessee, C.S.A., is reproduced on this and the following page. The letter was furnished The Journal by Colonel Thomas Spencer, 490 East Paces Ferry Road, N. E., Atlanta, Ga., through Dr. Frank K. Boland, of Atlanta.—Ed.

St. Mary's Hospital
Union Springs Alabama.
Sept. 30th 1864.

Dr.

Simon S. H. Stout
Med. Dir. Hospitals
Columbus Ga.

Sir, In Compliance with your excellent suggestion contained in Circular letter No 1 I would respectfully call attention to a simple and successful treatment of Hospital Gangrene instituted & practiced by Asst Surgeon E. M. Dasser in charge of this Hospital. It is the application of Red pepper poultices to the gangrenous wound & skin surrounding it. If Cayenne pepper cannot be had the common red pepper of the garden is just as efficacious. It should be cut up finely, or if dry, pulverized as much as possible in a mortar, & as much as is needed for an application should be mixed with an equal quantity of fine meal or ground flaxseed & made into a poultice large enough not only to cover the gangrenous part, but to envelope the whole limb or part for several inches around. They should be applied fresh every 3 or 4 hours and never suffered to become dry or hard, their use can be continued until the sloughs separate entirely & the wound has a decidedly healthy appearance, this will be known usually by the application becoming very painful to the patient. In addition to the local treatment the patient should be put on the use of Quinine & Whiskey, about 10 grs. of the former & 6 or 8 ounces of the latter per day. Since I have been on duty in this Hospital I have treated only two cases, one a very short time one, a wound from a Minnie ball passing through the arm near the insertion of the deltoid muscle fracturing the humerus; Iodine and

Oven:

Theorob, ferruphate of Iron with other active
 remedies has been diligently applied for days, but
 without arresting its progress. After 24 hours ap-
 plication of the pepper poultices, a remarkable
 change has taken place in the appearance of the
 wound, the 3rd day its sloughs has entirely separated
 the wound filled with healthy granulations & bathed
 in laudable pus, at this juncture the poultices were
 discontinued & the wound dressed with Elder oint-
 ment under the use of which the wound rapidly
 cicatrized. The second case treated as above
 yielded also in 36 hours. Dr. Casser informs
 me that he has treated a great many cases with
 this remedy & that he has never seen ~~one~~ that did
 not readily yield to it, As we are taught to believe
 that Hospital Gangrene is occasioned by some Specific
 poison which possibly disables the heart's action to
 such an extent that it cannot drive the Arterial
 current through the Capillaries adjacent to the
 wound & which too have become disabled by the same
 poison as well as encumbered by depositions thrown
 out during the inflammatory process, this treatment
 strikes as especially appropriate, the local treatment
 arouses the almost dormant energies of the overpowered
 Capillaries, whilst the Stimulant & tonic used
 internally goes to the Circulation & thus enables
 the system to throw off the disease.
 So remarkably efficacious has this treatment been
 in our limited experience, that I cannot but hope
 it will more greatly curtail the ravages of this
 terrible Malady.

Very Respectfully Yr. Obedt Servt

O. B. Knobel

Surgeon U.S.A.
H

THE JOURNAL

OF THE
MEDICAL ASSOCIATION OF GEORGIA

EDGAR D. SHANKS, M.D., Editor
478 Peachtree Street, N. E., Atlanta, Ga.

MARCH, 1951

PROGRAM FOR THE ANNUAL SESSION

Elsewhere in this Journal will be found the program for the 101st annual session of the Association; also the program for the Woman's Auxiliary to the Association.

Headquarters for the annual session will be Bon Air Hotel, Augusta. Other meetings, particularly those of the Woman's Auxiliary, will be held at Partridge Inn, which is across the street from the Bon Air.

Remember the dates for the meeting: April 17, 18, 19 and 20. Complete your plans now to attend as many of the meetings and social events as possible. If for any reason you experience trouble in obtaining proper accommodations, communicate with the Committee on Hotels of the Richmond County Medical Society, Augusta.

FORMATION OF AMERICAN MEDICAL EDUCATION FOUNDATION

The action of the Board of Trustees at the Cleveland meeting in appropriating one-half million dollars as the Association's initial contribution to an annual fund to be raised by the medical profession to assist the medical schools has been widely applauded as one of the most constructive and important programs ever undertaken by the American Medical Association. In announcing the establishment of this fund, the Board of Trustees expressed the hope that the Association's contribution would be greatly augmented by gifts from many other sources and urged all members of the Association to contribute individually. The initial response of the profession has been most gratifying. Many physicians in attendance at the Cleveland meeting inquired how they should make their contributions, and since the meeting letters requesting similar information have been received daily at Association headquarters.

It can now be announced that the American Medical Education Foundation has been established as a not-for-profit corporation, under the laws of the state of Illinois, to receive and distribute contributions to the fund from the individual members of the medical profession and friends of the profession. The Commissioner of Internal Revenue has been asked to rule that gifts to the foundation will be deductible in the computation of income taxes. An 11 man board of directors chosen from the Board of Trustees,

the officers of the Association and the Council on Medical Education and Hospitals will be responsible for arranging for the distribution of the funds to all approved medical schools. The funds are to be unrestricted, with each medical school free to determine how it can best use its share to further the basic training of its students. It is planned that the foundation will coordinate its activities closely with other major efforts to raise funds for medical education from voluntary sources, which it is hoped will be announced shortly.

Each member of the medical profession is urged to demonstrate his support of this new undertaking by contributing promptly and generously. Because of rising costs, inflation, fewer large individual benefactions and reduced income from endowments, the medical schools need, without further delay, assistance of the type this fund can give. It is the desire of the foundation that the first annual disbursement of funds to the medical schools be made this spring. It is clear that, if the foundation's contribution is to be an effective one, a substantial fund must be raised by the medical profession within the next few months. It is therefore urged that each physician consider an annual contribution of \$100. Many of the contributions already received exceed this figure. When a physician feels that this amount is beyond his means, smaller contributions will be welcome, but the profession must recognize that substantial sums are required and that token contributions alone will not be sufficient.

Almost every physician now practicing received his medical education for less than what it cost his medical school. While many physicians have discharged this debt to society in full or in part, by public and charitable activities and by donations to the schools with which they have been associated, many are still indebted to one or more medical schools for their training as students, interns or residents. Furthermore, the medical profession has traditionally accepted a large measure of responsibility for the training of the continuing flow of young physicians, on which it must depend for recruits and replacements in its efforts to serve humanity. It is to be expected, therefore, that all physicians, regardless of the other contributions they may have made to society, will want to share in the responsibility of making the foundation a success.

The American Medical Association has indicated its belief that the possibilities of securing adequate support for medical education from voluntary sources are far from exhausted. To prove this, actions as well as words are required. The challenge has now been made directly to the medical profession. The members of the profession can meet this challenge by sending their contributions today to the American Medical Education Foundation, 535 North Dearborn

Street, Chicago 10. Editorial *The Journal of the American Medical Association* January 20.

REPORT FATAL EFFECTS OF ANTIHISTAMINES ON CHILDREN

The disastrous effects of an overdose of antihistamine on young children as a result of accidental swallowing are compiled in a report by two physicians of the University of Michigan Medical School. Their observations serve as a warning to parents to keep these and other potent drugs out of the reach of children.

"The susceptibility of children to the convulsant action of antihistaminic agents is striking and impressive," Drs. James B. Wyngaarden and Maurice H. Seevers of Ann Arbor say in the February 3 *Journal of the American Medical Association*. They added that "the mortality rate in infants in whom convulsions develop is very high." Antihistamines are being widely used in treatment of allergic diseases and cold symptoms.

(Dr. Wyngaarden is presently located at Massachusetts General Hospital, Boston.)

According to the article, there are at least eight known deaths of children under two years of age attributed to these drugs. Five of the deaths were accompanied by convulsions.

Treatment of convulsions from antihistaminic agents in infants has been found to be "none too successful," they said, since treatment is entirely symptomatic as a specific antidote is lacking. Only two cases of recovery from convulsions caused by antihistaminic agents in children under two are known.

The doctors described the sudden death of a 22-month-old boy who had been in good health except for a mild upper respiratory tract infection. He was brought to a physician about two hours after the alleged swallowing of a number of dimenhydrinate tablets (used for motion sickness, such as seasickness and car-sickness). At first the baby was over-stimulated and later generalized convulsions and skin rash developed.

Despite efforts to save him, the child died 4½ hours after swallowing the drug. As a result of postmortem examination the dimenhydrinate was listed as the cause of death "either as a direct toxic effect or partially as an indirect change resulting from anoxia (oxygen deficiency)."

The more violent reaction of a three-year-old girl to an antihistamine was also reported in the article though, fortunately, the girl recovered.

The girl "was found in a drowsy, listless, fretful state. She became disorientated and walked with a staggering, awkward gait. Jerkings of the extremities developed, and then she experienced generalized clonic convulsions."

She had been playing 1½ hours earlier in the bathroom from which 17 capsules of diphenhydramine hydrochloride (used in treatment of allergies) were later found to be missing. Treat-

ment was begun about five hours after the supposed ingestion. The description of her condition continued:

"There were recurrent generalized convulsions for about eight hours; the face was flushed, and the pupils were dilated and nearly fixed. Between seizures the child cried out and talked in a rambling manner and showed hyperextension of the trunk (bowed stiffening of the back) and involuntary movements of the extremities. The next day she appeared normal."

The same issue of the *Journal* contains an editorial commenting on new controlled studies of the use of antihistamines in the treatment of colds. These included Navy male recruits during two influenza episodes.

Two antihistaminic drugs used in therapeutic dose "did not prevent the common cold or modify the course in those who developed colds," and showed no superiority over placebos (harmless pills containing no medication), the *Journal* points out.

DR. ELMER L. HENDERSON ELECTED EDUCATION FOUNDATION PRESIDENT

Dr. Elmer L. Henderson, Louisville, Ky., surgeon, took over the presidency of another medical organization today.

He was unanimously elected president of the new American Medical Education Foundation, which is raising funds within the medical profession for the unrestricted use of the nation's hard-pressed medical schools.

In addition to this office, Dr. Henderson is serving as president of the American Medical Association and president of the World Medical Association.

He was elected Foundation president at the first annual meeting of the 11-voting members of the not-for-profit corporation.

The members who approved the by-laws of the corporation and elected officers were: Drs. Edwin S. Hamilton, of Kankakee, Ill.; J. J. Moore, Donald G. Anderson, and George F. Lull, of Chicago; Gunnar Gundersen, LaCrosse, Wis.; Louis H. Bauer, Hempstead, N. Y.; Walter B. Martin, Norfolk, Va.; Harvey B. Stone, Baltimore; Herman G. Weiskotten, Syracuse, N. Y.; Victor Johnson, Rochester, Minn., and Dr. Henderson.

The voting members also will serve as the Board of Directors of the Foundation.

The Foundation was founded at the December, 1950, meeting of the American Medical Association in Cleveland when the Board of Trustees announced an appropriation of one-half million dollars as the nucleus of a fund to be raised by the medical profession to assist medical schools. When the Board announced the appropriation, hope was expressed that the A.M.A.'s contribution would be greatly augmented by gifts from many other sources.

Many contributions have been received so far, including one for \$100,000 from the California Medical Association. California is the first state medical association to make such a contribution, but it is expected that other state societies will follow.

Besides Dr. Henderson, other Foundation officers elected were: Dr. Stone, vice president, and Dr. Anderson, secretary of the Council on Medical Education and Hospitals of the American Medical Association, secretary and treasurer.

Dr. Bauer, chairman of the A.M.A. Board of Trustees, announced at the Foundation meeting that the American Medical Association had agreed to underwrite all of the expenses in connection with the operation of the Foundation.

"The American Medical Association," he told the Foundation, "will absorb all of the expenses of the Foundation so that none of the money contributed will be used to meet overhead. Every dollar contributed will go to the medical schools with no strings attached."

The Foundation announced, too, that a physician who so desires can earmark his money for a specific school. For instance, an alumnus can contribute whatever amount he wishes to the American Medical Education Foundation, specifying that it be given to his medical school.

The Foundation initiated plans to form Foundation committees within the 53 component state and territorial medical societies as well as within each county and district medical society. These committees will canvass the physicians in their own areas for funds.

The aim of the Foundation is to raise within the next few months a fund sufficiently large so that grants can be disbursed to medical schools this year with as little delay as possible.

Dr. Anderson said that each physician is being asked to contribute at least \$100 annually to the Foundation. "Many of the contributions received so far," he said, "have exceeded this figure. Because of rising costs, inflation, fewer large individual benefactions and reduced income from endowments, the medical schools need, without further delay, assistance of the type this fund can give."

The purpose of the Foundation, as set out in the newly-adopted by-laws, is "to promote the art and science of medicine and the betterment of the public health by providing or aiding in the providing of financial aid to recognized schools or institutions of medical education responsible for the education and training of the medical manpower of the United States."

REPORT ON STUDY OF REGIONAL BLOOD GROUP DISTRIBUTIONS

The blood type of 141,774 men and women who voluntarily contributed blood to the American Red Cross from January 1948 through March

1941 is the subject of a report in the January 13 *Journal of the American Medical Association*.

The information was gathered from 15 representative cities and their outlying areas. The regions included: Yakima, Wash.; Rochester, N. Y.; Detroit; Massachusetts (42.3 degrees latitude north); Omaha; Columbus, O.; Washington; St. Louis; Stockton, Calif.; Wichita, Kan.; San Jose, Calif.; Springfield, Mo.; Charlotte, N. C.; Los Angeles and Atlanta.

The total percentage of persons falling into each blood type from all 15 regions was as follows: O blood group, 45.55 per cent; A, 40.77 per cent; B, 9.96 per cent; and AB, 3.72 per cent. The O type blood can be used in all transfusions regardless of blood type of the recipient.

"In the event of an emergency requiring large quantities of blood," the report said in part, "the southern areas now appear to be comparatively favorable sources of O and the northern areas of B."

The results showed, to some extent, that for each degree of latitude proceeding from north to south the O group percentage increased, on the average, .32 per cent. From north to south the B group percentage decreased .17 per degree of latitude. No east-west trends were discovered.

The report brought out that from region to region the greater the O, A or B percentage, the smaller on the average was the percentage for the remaining groups within the trio, but AB group "tended to be stable."

In conclusion the report said that "population changes could be responsible for marked changes (in regional location of blood types) within the span of a very few years."

Associates of the American Red Cross who made the study were: George W. Hervey, Sc.D.; Dr. Louis K. Diamond and Virginia Watson, M. S., of Washington, D. C.

VIRTUES

Thank God every morning, when you get up, that you have something to do that day which must be done whether you like it or not. Being forced to work and forced to do your best, will breed in you temperance and self-control, diligence and strength of will, cheerfulness and a hundred virtues which the idle man will never know—Selected.

Have you ever thought of the difference between a tree and a post? It is only a matter of life. Set a post in the ground and it begins to decay. The tree lives while the post dies. Which are you—a tree or a post? Be a tree and live and grow.—Selected.

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The officers of the Medical Association of Georgia urge its members to attend the One Hundred First Annual Session of the Association, Augusta, April 17-20, 1951. Note pages 132-136 of this *Journal*.

The House of Delegates will convene, Tuesday, April 17, at 2:00 p.m. at the Bon Air Hotel. The scientific session will open April 18, at 8:30 a.m., at the Bon Air Hotel.

CAT.



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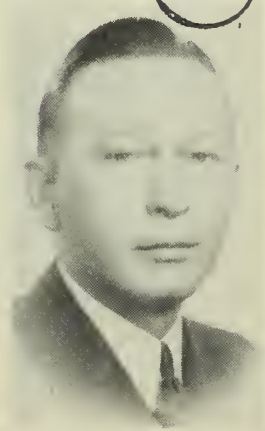
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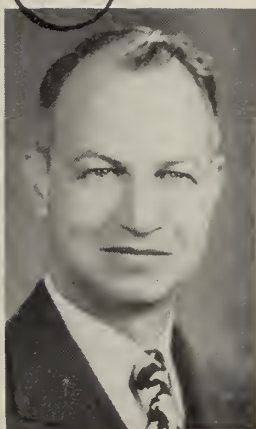
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Augusta

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Viola Berry

Atlanta

Executive Secretary

ONE HUNDRED FIRST ANNUAL SESSION

Augusta

April 17, 18, 19, 20, 1951

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Edgar H. Greene	President, 1948-1949
Enoch Callaway	President, 1949-1950

RICHMOND COUNTY MEDICAL SOCIETY

Officers and Committees

President	Goodwin, Thomas W., Augusta
President-Elect	Brown, Stephen W., Augusta
Vice-President	Roule, J. Victor, Augusta
Secretary-Treasurer	Philpot, W. K., Augusta
Delegate	Thomas, David R., Augusta
Delegate	Martin, John M., Augusta
Delegate	McGahee, R. C., Augusta
Alternate Delegate	Roule, J. Victor, Augusta
Alternate Delegate	Miller, John M., Augusta
Alternate Delegate	Harrison, F. N., Augusta

COMMITTEES

All of Augusta

General Committee

R. C. McGahee, Chairman; C. M. Mulherin, David R. Thomas, and Thomas W. Goodwin.

Hotels

Perry P. Volpitto, Chairman; David A. Davis, John L. Chandler, Jr., and Peter B. Wright.

Entertainment

Peter B. Wright, Chairman; Perry P. Volpitto, David A. Davis, and John L. Chandler, Jr.

Alumni Dinner

Medical College of Georgia

P. A. Mulherin, Chairman; W. J. Williams, Thomas E. Bailey, and David R. Thomas.

Alumni Dinner

Emory University School of Medicine

Harry T. Harpe, Jr., Chairman; John T. Persall, and William A. Fuller.

Publicity

J. Robert Rinker, Chairman; M. H. Wylie and
H. D. Pinson.

Golf

J. P. Hitchcock, Chairman; J. Victor Roule, and
R. L. Rhodes.

Transportation

John M. Martin, Chairman; Gordon M. Kelly, and
Thomas L. Clary, Jr.

MEDICAL ASSOCIATION OF GEORGIA

COMMITTEES

Scientific Work

W. C. McGeary, Chairman Madison
Richard Torpin Augusta
Thomas L. Ross, Jr. Macon
Edgar D. Shanks Atlanta

Public Policy and Legislation

C. C. Aven, Chairman Atlanta
Jack C. Norris Atlanta
James A. Johnson, Jr. Manchester
T. F. Sellers Atlanta
A. M. Phillips Macon
Edgar D. Shanks Atlanta

Medical Defense

Marion C. Pruitt, Chairman Atlanta
B. H. Minchew Waycross
Marcus Mashburn Cumming
Edgar D. Shanks Atlanta

Advisory State Board of Health

Edgar H. Greene, Chairman Atlanta
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J. C. Patterson Cuthbert
R. K. Winston Tifton
O. R. Styles Cedartown
J. C. Brim Pelham
J. W. Chambers LaGrange
C. L. Ayers Toccoa
D. N. Thompson Elberton
B. H. Minchew Waycross

Medical Education and Hospitals

G. Lomhard Kelly, Chairman Augusta
R. Hugh Wood Emory University
Julian K. Quattlebaum Savannah
Ernest F. Wahl Thomasville
J. A. Thrash Columbus
C. Mark Whitehead LaGrange
L. Minor Blackford Atlanta
B. T. Beasley Atlanta
Charles B. Fulghum Milledgeville
John T. McCall, Jr. Rome
A. C. Little, Jr. Valdosta
Marcus Mashburn, Jr. Cumming
Sam M. Talmadge Athens
C. H. Richardson, Sr. Macon
Hervey M. Cleckley Augusta
Albert F. Brawner Atlanta
Edgar Boling Atlanta

Abner Wellborn Calhoun Lectureship

James E. Paullin, Chairman Atlanta
J. R. Broderick Savannah
Eugene E. Murphey Augusta
Frank K. Boland Atlanta
Guy O. Whelchel Athens
J. Calhoun McDougall Atlanta

Memorial Exercises

M. Preston Agee, Chairman Augusta
L. D. Porch Macon
J. C. Patterson Cuthbert
George H. Lang Savannah
Frank K. Boland Atlanta
M. T. Edgerton Atlanta

Medical History of Georgia

J. Calvin Weaver, Chairman Atlanta
Frank K. Boland Atlanta
Allen H. Bunce Atlanta

T. F. Abercrombie Decatur
Eugene E. Murphey Augusta
William R. Dancy Savannah
McClaren Johnson Atlanta

Orthopedics

J. Hiram Kite, Chairman Atlanta
Fred G. Hodgson Atlanta
Thomas P. Goodwyn Atlanta
F. Bert Brown Savannah
John I. Hall Macon
Peter B. Wright Augusta
W. A. Newman Macon
H. Walker Jernigan Atlanta
C. E. Irwin Warm Springs
Lawson Thornton Atlanta
C. G. Henry Augusta

Industrial Health

C. N. Wasden, Chairman Macon
J. Harry Rogers Atlanta
Thomas P. Goodwyn Atlanta
T. V. Willis Brunswick
L. M. Petrie Atlanta
W. W. Battey Augusta
Chas. E. Lawrence Atlanta
W. A. Newman Macon
C. F. Holton Savannah
John P. Garner Atlanta
J. H. Mull Rome
Rufus A. Askew Atlanta

Student Loan Fund

Mrs. Shelley C. Davis, Chairman Atlanta
G. Lombard Kelly Augusta
R. Hugh Wood Emory University

Scientific Exhibits

Robert B. Greenblatt, Chairman Augusta
J. Elliott Scarborough Emory University
Marion T. Benson, Jr. Atlanta
Lee Howard Savannah
Robert C. Pendergrass Americus
Julian K. Quattlebaum Savannah
J. Hiram Kite Atlanta
Max Mass Macon
Clair A. Henderson Savannah
Leila Denmark Atlanta
M. Fernan-Nunez Dublin

Medical Preparedness

W. A. Selman, Chairman Atlanta
Alternate, L. Minor Blackford Atlanta
A. O. Linch Atlanta
Alternate, John W. Turner Atlanta
Edgar D. Shanks Atlanta
Alternate, Spencer A. Kirkland Atlanta

Postgraduate Study

R. Hugh Wood, Chairman Emory University
G. Lombard Kelly Augusta
R. H. Oppenheimer Atlanta
Thomas L. Ross, Jr. Macon
Hollis Hand LaGrange
Richard Torpin Augusta
Cleveland Thompson Waynesboro
C. H. Richardson, Jr. Macon
F. H. Simonton Chickamauga
Vernon E. Powell Atlanta
John Sharpley Savannah
J. M. Byne, Jr. Waynesboro

*Liaison Committee**Georgia State Medical Association
(Negro)*

J. F. Hanson, Chairman Macon
J. R. McCord Atlanta
W. E. Storey Columbus
Lee H. Battle, Jr. Rome
E. Van Buren Atlanta
H. H. Allen Decatur

Awards

C. H. Richardson, Sr., Chairman	Macon
T. Schley Gatewood	Americus
G. Lombard Kelly	Augusta
W. W. Baxley	Macon
W. S. Dorough	Atlanta
Mason I. Lowance	Atlanta
J. Dean Paschal	Dawson

Cancer Commission

J. Elliott Scarborough, Chairman	Emory University
Everett L. Bishop	Atlanta
Robert C. Pendergrass	Americus
Thomas Harrold	Macon
Enoch Callaway	LaGrange
Lee Howard	Savannah
W. F. Jenkins	Columbus
J. T. McCall (Deceased)	Rome
Hoke Wammock	Augusta
D. M. Bradley	Waycross
John Funke	Atlanta
J. J. Collins	Thomasville
Max Mass	Macon

Advisory Woman's Auxiliary

Murdock Euen, Chairman	Atlanta
L. W. Williams	Savannah
J. R. S. Mays	Macon
Eustace A. Allen	Atlanta
W. Bruce Schaefer	Toccoa
Ralph H. Chaney	Augusta
W. L. Bazemore	Macon
J. Harry Rogers	Atlanta
W. G. Elliott	Cuthbert

Revision of Pharmacopeia of U. S.

Allen H. Bunce, Chairman	Atlanta
C. C. Aven	Atlanta
Hal M. Davison	Atlanta

Prepayment Medical Care Plans

W. S. Dorough, Chairman	Atlanta
John L. Elliott	Savannah
Steve P. Kenyon	Dawson
Kenneth D. Grace	LaGrange
A. M. Phillips	Macon
W. L. Pomeroy	Waycross
D. Lloyd Wood	Dalton
C. K. Wall	Thomasville
H. L. Cheves	Union Point
W. Bruce Schaefer	Toccoa

Committee to Revise the Constitution

Allen H. Bunce, Chairman	Atlanta
C. H. Richardson, Sr.	Macon
Marion C. Pruitt	Atlanta
W. F. Reavis	Waycross
John A. Dunaway, Attorney for Association	Atlanta
A. M. Phillips, President	Macon
Edgar D. Shanks, Secretary-Treasurer	Atlanta

*Liaison Committee of 53 Constituent**State Medical Associations to Coordinate Educational Program of A.M.A.*

Jack C. Norris	Atlanta
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Group Insurance

John W. Turner, Chairman	Atlanta
Kenneth S. Hunt	Griffin
James H. Arnold	Newnan
Roy L. Gibson	Columbus
F. H. Sams	Reynolds
Frank M. Houser	Macon
E. S. Colvin	Atlanta

Medical Civilian Preparedness

Edgar M. Dunstan, Chairman	Atlanta
Robert W. Candler	Atlanta
Charles E. Dowman	Atlanta
Joseph S. Skobba	Atlanta
Walter M. Bartlett	Decatur
Alvin E. Siegel	Macon
J. H. Pinholster	Savannah

W. K. Philpot	Augusta
T. J. Ferrell	Waycross

Public Relations Committee

Stephen T. Brown, Chairman	Atlanta
Christopher J. McLoughlin	Atlanta
W. G. Elliott	Cuthbert
J. E. Penland	Waycross
W. D. Hall	Calhoun
Thomas L. Ross, Jr.	Macon
Hartwell Joiner	Gainesville
Ralph H. Chaney	Augusta
Emery C. Herman	LaGrange

Pediatrics

W. W. Anderson, Chairman	Atlanta
Philip A. Mulherin	Augusta
Frank Schley	Columbus
Edwin R. Watson	Macon
M. M. McCord	Rome
Howard J. Morrison	Savannah
W. Charles Boswell	Macon
A. M. Johnson	Valdosta
Leila Denmark	Atlanta

Maternal Care

C. B. Upshaw, Chairman	Atlanta
Guy V. Rice, Secretary	Atlanta
T. F. Sellers	Atlanta
Richard Torpin	Augusta
E. D. Colvin	Atlanta
John R. McCain	Atlanta
Evelyn Swilling	Macon

Tuberculosis

Samuel E. Patton, Chairman	Macon
C. C. Aven	Atlanta
Rufus F. Payne	Rome
H. C. Schenck	Atlanta
Robert C. Major	Augusta

Federal Delegates to Other States

Alabama—Enoch Callaway, LaGrange; Roy L. Gibson, Columbus; Edwin T. Arnold, Jr., Hogansville; Harry B. Baxley, Donalsonville.

Florida—Braswell E. Collins, Waycross; J. L. Campbell, Jr., Valdosta; Rudolph Bell, Thomasville; H. M. McKemie, Albany.

North Carolina—Thomas J. Hicks, McCaysville; Hartwell Joiner, Gainesville; B. J. Roberts, Cornelia.

South Carolina—D. R. Thomas, Augusta; Hubert Milford, Hartwell; Anne Hopkins, Savannah.

Tennessee—F. H. Simonton, Chickamauga; D. Lloyd Wood, Dalton; Ralph N. Johnson, Rome.

*STATE BOARD OF HEALTH**

First District: James M. Byne, Jr., Waynesboro, Sept. 1, 1951.

Second District: C. K. Sharp, Arlington, Sept. 1, 1951.

Third District: R. C. Montgomery, Butler, Sept. 1, 1954.

Fourth District: M. M. Head, Zebulon, Sept. 1, 1955.

Fifth District: Spencer A. Kirkland, Atlanta, Sept. 1, 1954.

Sixth District: Walter Bramblett, Jr., Forsyth, Sept. 1, 1956.

Seventh District: Fred H. Simonton, Chickamauga, Sept. 1, 1956.

Eighth District: C. J. Maloy, McRae, Sept. 1, 1956.

Ninth District: Robert L. Rogers, Gainesville, Sept. 1, 1951.

Tenth District: Thos. W. Goodwin, Augusta, Sept. 1, 1955.

*STATE OF GEORGIA AT LARGE****Georgia Dental Association*

J. M. Hawley, Columbus, Sept. 1, 1952.

J. G. Williams, Atlanta, Sept. 1, 1952.

Georgia Pharmaceutical Association

Preston Sumner, East Point, Sept. 1, 1953.

A. T. McRae, Douglas, Sept. 1, 1956.

*Nominated by their respective district medical societies and appointed for six-year terms.

**Nominated by their respective associations.

STATE BOARD OF MEDICAL EXAMINERS

Edgar H. Greene	Atlanta
J. W. Palmer	Ailey
Steve P. Kenyon	Dawson
Grady N. Coker	Canton
R. H. McDonald	Newnan
Phil E. Roberson	Albany
Fred J. Coleman	Dublin
Alexander B. Russell	Winder
Rufus A. Askew	Atlanta
W. H. Powell	Hazlehurst

DISTRICT SOCIETIES

OFFICERS AND MEETING DATES

First District

President—A. Bird Daniel, Statesboro
 Secretary—Wm. H. Fulmer, Savannah
 Third Wednesday—March and July.

Second District

President—Robert M. Joiner, Moultrie
 Secretary—Frank A. Little, Thomasville
 Second Thursday—April and October.

Third District

President—Russell Thomas, Americus
 Secretary—T. Schley Gatewood, Americus
 Third Wednesday in June—Second Wednesday in November.

Fourth District

President—H. Hilt Hammett, Jr., LaGrange
 Secretary—Treasurer—James M. Bryant, Jr., Newnan
 Second Wednesday—February and August.

Fifth District

President—Carter Smith, Atlanta
 Secretary—L. M. Blackford, Atlanta.
 No set dates.

Sixth District

President—Leon D. Porch, Macon
 Secretary—Treasurer—C. H. Richardson, Jr., Macon
 Last Wednesday in June—First Wednesday in December.

Seventh District

President—S. M. Howell, Cartersville
 Secretary—S. B. Kitchens, Lafayette
 First Wednesday in April—last Wednesday in September.

Eighth District

President—J. B. Avera, Brunswick
 Secretary—James L. Campbell, Jr., Valdosta
 Second Tuesday—April and October.

Ninth District

President—J. L. Walker, Clarksville
 Secretary—Hartwell Joiner, Gainesville
 Dates not specified.

Tenth District

President—M. C. Adair, Washington
 Secretary—A. W. Simpson, Jr., Washington
 Second Wednesday—February and August.

DELGATES TO THE 1951 SESSION

<i>Counties</i>	<i>Names and Addresses</i>
Appling	James A. Bedingfield, Baxley
Baldwin	Robert D. Waller, Milledgeville
Banks	J. S. Jolley, Homer
Bartow	
Ben Hill	
Bibb	J. D. Applewhite, Macon
	J. B. Kay, Byron
Blue Ridge	James F. O'Daniel, Ellijay
Brooks	L. A. Smith, Quitman
Bulloch-Candler-Evans	John Mooney, Jr., Statesboro
Burke	Cleveland Thompson, Sr., Waynesboro
Carroll-Douglas-Haralson	Wm. P. Downey, Tallapoosa
Chatham—	
Georgia Medical Society	John L. Elliott, Savannah
	Ruskin King, Savannah
	Ralph O. Bowden, Savannah
Chattooga	G. H. Little, Trion

Cherokee-Pickens	Ben K. Looper, Canton
Clarke	M. A. Hubert, Athens
Clayton-Fayette	T. J. Busey, Fayetteville
Cobb	
Coffee	L. H. Shellhouse, Willacoochee
Colquitt	A. G. Funderburk, Moultrie
Columbia	
Coweta	G. W. Hammond, Newnan
Crisp	P. L. Williams, Cordele
Decatur-Seminole	Harry B. Baxley, Donalsonville
DeKalb	Rufus J. Evans, Stone Mountain
Dooley	O. K. Coleman, Vienna
Dougherty	Paul T. Russell, Albany
Elbert	
Emanuel	D. D. Smith, Swainsboro
Floyd	
Forsyth	
Franklin	Stewart D. Brown, Royston
Fulton	William G. Hamm, Atlanta
	Hal M. Davison, Atlanta
	William A. Smith, Atlanta
	Tully T. Blalock, Atlanta
	A. O. Linch, Atlanta
	Jack C. Norris, Atlanta
	John W. Turner, Atlanta
	B. L. Shackleford, Atlanta
	J. D. Martin, Jr., Atlanta
	Edgar Boling, Atlanta
	C. Purcell Roberts, Atlanta
	W. S. Dorrough, Atlanta
	C. A. Wilson, Jr., Brunswick
Glynn	
Gordon	
Grady	
Greene	
Gwinnett	
Habersham	Geo. T. Nicholson, Cornelia
Hall	Billy S. Hardman, Gainesville
Hancock	C. S. Jernigan, Sparta
Hart	
Henry	
Houston-Peach	A. Smoak Marshall, Fort Valley
Jackson-Barrow	Alex B. Russell, Winder
Jasper	E. M. Lancaster, Shady Dale
Jefferson	C. Roy Williams, Wadley
Jenkins	A. P. Fortney, Sylvania
Lamar	J. A. Corry, Barnesville
Laurens	John A. Bell, Jr., Dublin
Macon	
McDuffie	
Meriwether-Harris	Robert L. Bennett, Warm Springs
Mitchell	J. C. Brim, Pelham
Monroe	George H. Alexander, Forsyth
Montgomery	J. W. Palmer, Ailey
Morgan	J. H. Nicholson, Madison
Muscooke	Roy L. Gibson, Columbus
	George M. Hutto, Columbus
Newton	
Ocmulgee—	
Bleckley-Dodge-Pulaski	
Polk	W. H. Lucas, Cedartown
Rahun	
Randolph-Terrell	Ernest F. Daniel, Dawson
Richmond	Robert C. McGahee, Augusta
	David R. Thomas, Jr., Augusta
	John M. Martin, Augusta
	Harvey E. Griggs, Conyers
Rockdale	
Scriven	
South Georgia: Berrien-Clinch-Cook-Echols—	
Lanier-Lowndes	A. G. Little, Jr., Valdosta
Spalding	Kenneth S. Hunt, Griffin
Stephens	Robert E. Shiflet, Toccoa
Sumter	
Tattall	A. G. Pinkston, Jr., Glennville
Taylor	R. C. Montgomery, Butler
Telfair	F. R. Mann, Jr., McRae
Thomas	George R. Dillinger, Thomasville
Tift	C. S. Pittman, Jr., Tifton
Toombs	H. D. Youmans, Lyons

Tri-County:	
Calhoun-Early-Miller	W. O. Shepard, Bluffton
Tri-County—	
Liberty-Long-McIntosh	I. G. Armistead, Townsend
Troup	
Turner	
Upson	
Walker-Catoosa-Dade	Fred H. Simonton, Chickamauga
Walton	Lynn M. Huie, Monroe
Ware	W. L. Pomeroy, Waycross
Warren	H. B. Cason, Warrenton
Washington	Emory G. Newsome, Sandersville
Wayne	Robert A. Pumpelly, Jesup
Whitfield	Tranmell Starr, Dalton
Wilcox	V. I. Harris, Rochelle
Wilkes	A. Dan Duggan, Washington
Worth	J. L. Tracy, Jr., Sylvester

ANNOUNCEMENTS

Be sure to go to the Registration Desk at the Bon Air Hotel after your arrival, present your 1951 membership card, register and procure a badge and program.

Discussion of papers is open to all members and guests of the Association; it is not limited to those named on the program.

On arising to discuss a paper the speaker will please announce his name and address clearly for the benefit of the Association and the reporter.

Meetings will be called to order at the hour fixed on the program. It is especially desired that the members be prompt in their attendance.

All manuscripts should be typewritten, double spaced, and on one side of the paper only. Papers must be handed to the reporter immediately after being read.

IMPORTANT NOTICE

Delegates must present written credentials to the Committee on Credentials of the House of Delegates to secure delegates' badges.

Members may not take part in the proceedings until they have registered and procured official badges.

PUBLIC MEETINGS

BON AIR HOTEL

WEDNESDAY, APRIL 18, 8:30 A. M.

Eastern Standard Time

Open Meeting

WEDNESDAY, APRIL 18, 8:00 P. M.

President's Address

The President's Address will be at an open session to which the public and visitors are invited.

Presentation of the President's Gold Key to President Alpheus Maynard Phillips, Macon, by C. H. Richardson, Sr., Macon.

THURSDAY, APRIL 19, 12:00 NOON

MEMORIAL EXERCISES

M. Preston Agee, Augusta

Chairman, Committee on Necrology

ENTERTAINMENT

At the time of going to press, plans for the various entertainments have not been completed. All such plans will be listed in the final pocket edition of the program.

MEETINGS OF THE HOUSE OF DELEGATES

BON AIR HOTEL

TUESDAY, APRIL 17, 2:00 P. M.

Eastern Standard Time

First meeting of the House of Delegates

1. Call to order by the President
2. Roll Call
3. Appointment of Reference Committees

4. Reports of officers:

President
President-Elect
Vice-Presidents
Parliamentarian
Secretary-Treasurer: Financial report
Reports of Delegates to the A.M.A.

5. Reports of committees:

Scientific Work
Public Policy and Legislation
Arrangements
Medical Defense
Advisory State Board of Health
Medical Education and Hospitals
Abner Wellborn Calhoun Lectureship
Necrology
Medical History
Orthopedics
Industrial Health
Medical Preparedness
Cancer Commission
Awards
Advisory—Woman's Auxiliary
Prepayment Medical Care Plans
Public Relations
Maternal Care
Tuberculosis
Special Committees

6. Unfinished Business

7. New Business.

TUESDAY, APRIL 17, 8:00 P. M.

Eastern Standard Time

BON AIR HOTEL

Second meeting of the House of Delegates.

1. Call to order by the President
2. Reading of minutes
3. Announcements
4. Report of President of Woman's Auxiliary
5. Reports of committees (continued)
6. Reports of Fraternal Delegates
7. Unfinished business
8. New business

FRIDAY, APRIL 20, 8:30 A. M.

Eastern Standard Time

BON AIR HOTEL

Third meeting of the House of Delegates

1. Call to order by the President
2. Reading of minutes
3. Reports of committees
4. Unfinished business
5. New business.

OFFICIAL REPORTER

The Master Reporting Company, Inc.

MEETINGS OF THE COUNCIL

TUESDAY, APRIL 17, 4:30 P. M.

Eastern Standard Time

BON AIR HOTEL

The first meeting of the Council will be held Tuesday, April 17, following the afternoon session of the House of Delegates. Each Councilor will render a report of conditions of each county of his district. Other meetings of the Council will be held on the call of the chairman.

SCIENTIFIC PROGRAM

WEDNESDAY, APRIL 18, 8:30 A. M.

Eastern Standard Time

BON AIR HOTEL

The papers for each meeting MUST be read as scheduled on the program.

Call to order by the President, Alpheus Maynard Phillips, Macon.

Invocation

THE REV. ZACH C. HAYES, Augusta
Pastor, St. John's Methodist Church

Address of Welcome

THOMAS W. GOODWIN, Augusta
President, Richmond County Medical Society

Response to Address of Welcome

WM. R. DANCY, Savannah

Nominations for Officers and Delegates to A.M.A.

SCIENTIFIC PROGRAM

WEDNESDAY, APRIL 18, 8:30 A. M.

Eastern Standard Time

BON AIR HOTEL

The time allotted to each paper, which INCLUDES the showing of slides or moving pictures, is 12 minutes.

1. Spontaneous Pneumothorax.
George R. Dillinger, Thomasville.
2. The Significance and Management of Solitary Pulmonary Masses.
Ted F. Leigh, Emory University
Osler A. Abbott, Emory University
William A. Hopkins, Emory University
William E. VanFleit, Emory University
3. The Clinical Recognition and Treatment of Pulmonary Embolism and its Prodromes.
Haywood N. Hill, Atlanta.
To open the discussion of papers 1, 2 and 3:
Rufus F. Payne, Rome
C. E. Rushin, Atlanta
Raymond F. Corpe, Rome
Recess of 15 minutes to visit exhibits.
4. Chloromycetin Treatment of Typhoid Fever.
D. F. Mullins, Jr., Athens
William H. Bonner, Athens.
5. The Basic Concepts of Allergic Disease.
Ellison R. Cook, III, Savannah.
To open the discussion of papers 4 and 5:
T. F. Sellers, Atlanta
C. Raymond Arp, Atlanta.
6. Diabetes Detection in Georgia.
Christopher J. McLoughlin, Atlanta
Lester M. Petrie, Atlanta
Richard H. Fetz, Atlanta.
7. The Medical Care of Service-Connected Diabetics in Georgia.
A. Park McGinty, Atlanta.
To open the discussion of papers 6 and 7:
Arthur M. Knight, Jr., Waycross
L. Quinby Hair, Augusta
8. The Etiology and Treatment of Fever Blisters.
Jack C. Norris, Atlanta.
To open the discussion of paper 8:
C. K. McLaughlin, Macon
Grady Coker, Canton.

WEDNESDAY, APRIL 18, 12:00 NOON

Eastern Standard Time

BON AIR HOTEL

ABNER WELLBORN CALHOUN LECTURE

Neurovascular Syndromes of the Shoulder Girdle, Including Hyperabduction Syndrome

Irving S. Wright, New York City
Introduction by James E. Paullin, Atlanta.

WEDNESDAY, APRIL 18, 2:30 P. M.

Eastern Standard Time

BON AIR HOTEL

The time allotted to each paper, which INCLUDES the showing of slides or moving pictures, is 12 minutes.

1. Hermaphroditism: Report of Case.
Thomas R. Freeman, Savannah.

2. The Treatment of an Unusual Case of Anuria.
Rafe Banks, Jr., Atlanta
John P. Hill, Atlanta.
3. Modern Treatment of Urinary Infections.
Harold P. McDonald, Atlanta.
To open the discussion of papers 1, 2 and 3:
Marion A. Hubert, Athens
Robert W. McAllister, Macon.
4. Plastic Repair of Defects of the Mouth.
W. Stewart Flanagan, Augusta.
5. The Role of Cerebral Angiography in the Management of Cerebral Vascular Accidents.
James R. Simpson, Atlanta
Exum Walker, Atlanta
William W. Moore, Atlanta.
To open the discussion of papers 4 and 5:
John R. Lewis, Jr., Atlanta
W. A. Risteen, Augusta.
6. What Every Georgia Physician Should Know About Civil Defense.
Edgar M. Dunstan, Atlanta.
7. Problems in the Procurement of Physicians for the Armed Forces.
Carter Smith, Atlanta
Col. Holmes Ginn, Fort McPherson
Lt. C. H. Lindsey, Jr., Atlanta.
Discussion of papers 6 and 7:
Questions and Answers.

WEDNESDAY, APRIL 18, 8:00 P. M.

Eastern Standard Time

BON AIR HOTEL

President's Address

The Physician's Responsibility

ALPHEUS MAYNARD PHILLIPS, Macon

Presentation of the President's Gold Key to the President, Alpheus Maynard Phillips, Macon, by Charles H. Richardson, Sr., Macon.

The Evolution of a Specialty

CURTICE ROSSER, Dallas, Texas

Introduction by Marion C. Pruitt, Atlanta.

What American Doctors Are Doing

GEORGE F. LULL, Chicago, Ill.

Secretary and General Manager

American Medical Association

Introduction by Allen H. Bunce, Atlanta.

THURSDAY, APRIL 19, 8:30 A. M.

Eastern Standard Time

BON AIR HOTEL

The time allotted to each paper, which INCLUDES the showing of slides or moving pictures, is 12 minutes.

1. Cortisone and the Adreno-Genital Syndrome.
Peter L. Scardino, Savannah.
2. The Use of ACTH and Cortisone in the Treatment of Anorexia Nervosa.
Robert B. Greenblatt, Augusta
William E. Barfield, Augusta
Sarah L. Clark, Augusta.
3. The Adrenal Cortex and Allergic Reactions.
William F. Friedewald, Atlanta.
To open the discussion of papers 1, 2 and 3:
V. P. Sydenstricker, Augusta
Max M. Blumberg, Atlanta
4. Medical Education and Medical Care.
R. Hugh Wood, Emory University.
5. Program for Intern Training for General Practice.
G. Lombard Kelly, Augusta.
6. The Ultimate Aim of Voluntary Health Insurance Plans.
W. S. Dorough, Atlanta.
To open the discussion of papers 4, 5 and 6:
C. L. Ridley, Sr., Macon
D. Lloyd Wood, Dalton.
Recess of 15 minutes to visit exhibits.

7. The Problem of Psychic Versus Somatic Disease.
Henry H. Tift, Macon
W. Derrel Hazlehurst, Macon.
 8. The Contribution of Psychiatry to the Role of the Medical Practitioner.
Rives Chalmers, Atlanta.
 9. Shock Therapy: A Review of the Literature and Results of Treatment.
Harry R. Lipton, Atlanta.
- To open the discussion of papers 7, 8 and 9:
H. Dawson Allen, Milledgeville.
Hervey Cleckley, Augusta.

THURSDAY, APRIL 19, 12:00 NOON

Eastern Standard Time

BON AIR HOTEL

Memorial Exercises

M. PRESTON AGEE, Augusta
Chairman, Committee on Necrology
Rev. Clifton A. Forrester, Augusta
Mrs. Robert J. Watson, Augusta, Organist
Mrs. Eugenia Bruker, Augusta, Soloist.

THURSDAY, APRIL 19, 2:30 P. M.

Eastern Standard Time

BON AIR HOTEL

The time allotted to each paper, which INCLUDES the showing of slides or moving pictures, is 12 minutes.

1. Georgia's Program for the Crippled Child.
William Littell Funkhouser, Atlanta.
To open the discussion of paper 1:
Fred G. Hodgson, Atlanta
W. A. Newman, Macon.
 2. Culdoscopy: A Versatile Diagnostic Aid.
John H. Ridley, Atlanta.
 3. Abdominal Puncture as a Diagnostic Aid.
Charles M. Henry, Toccoa.
 4. Surgery of the Upper Gastrointestinal Tract: A Five Year Report.
B. Hollis Hand, LaGrange.
 5. The Surgical Treatment of Gastric Ulcer.
Duncan Shepard, Atlanta.
 6. Postoperative Loss of Potassium and its Clinical Significance.
David D. Merren, Atlanta.
 7. The Incidence of Malignancy in Hysterectomy for Benign Conditions.
Olin S. Cofer, Atlanta
Albert L. Evans, Atlanta.
 8. The Incidence of Carcinoma in Nodular Thyroids in this Section.
Charles H. Watt, Thomasville.
John Foushee, Thomasville.
- To open the discussion of papers 2, 3, 4, 5, 6 and 7:
Lon W. Grove, Atlanta
J. K. Quattlebaum, Savannah

FRIDAY, APRIL 20, 9:00 A. M.

Eastern Standard Time

BON AIR HOTEL

The time allotted to each paper, which INCLUDES the showing of slides or moving pictures, is 12 minutes.

1. Duodenal Adenoma.
George T. Nicholson, Cornelia.
To open the discussion of paper 1:
C. W. Hock, Augusta
W. F. Hamilton, Jr., Augusta.
2. Vocational Rehabilitation of Cardiac Patients.
Joseph C. Massee, Atlanta.
To open the discussion of paper 2:
Harry T. Harper, Jr., Augusta.
Thomas L. Ross, Jr., Macon.
3. Anesthesia for Femoral Neck and Intertrochanteric Fractures.
Kathleen Byers, Atlanta.

To open the discussion of paper 3:

Peter B. Wright, Augusta

A. J. Waters, Augusta.

4. Labor Associated with Contracted Pelvis.

Alva Faulkner, Augusta

B. A. Brooks, Augusta.

To open the discussion of paper 4:

Hugh J. Bickerstaff, Columbus.

5. The Surgical Treatment of Cancer of the Maxillary Antrum.

Sam A. Wilkes, Jr., Emory University.

To open the discussion of paper 5:

Robert L. Brown, Emory University

J. Victor Roule, Augusta.

Recess of 15 minutes to visit exhibits.

6. Reducing Pain in Post Rectal Surgery.

Henry E. Steadman, Hapeville.

7. Rectal Bleeding.

Leonard J. Rabhan, Savannah.

8. Back Pain.

Paul L. Rieth, Emory University.

Edgar F. Fincher, Emory University.

To open the discussion of papers 6, 7 and 8:

Marion C. Pruitt, Atlanta

F. Bert Brown, Savannah.

9. Alcoholic Anonymous from its Psychiatric Aspects.

B. A. Thompson, Milledgeville

To open the discussion of paper 9:

J. R. S. Mays, Macon

James N. Brawner, Jr., Smyrna.

ANNOUNCEMENT OF ELECTION OF OFFICERS AND DELEGATES TO A. M. A.

President-Elect

First Vice-President

Second Vice-President

Secretary-Treasurer

Delegates to the A.M.A.

Councilors:

Ninth District

Tenth District

Selection of meeting place for 1952.

CONSTITUTION AND BY-LAWS

Chapter II, Section 2. No papers or addresses before the Association, except those of the President and invited essayists, shall occupy more than fifteen minutes in their delivery; and no member shall speak longer than five minutes, nor more than once on any subject, provided that each essayist shall have five minutes in which to close the discussion of his paper.

Chapter VIII, Section 1. The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Chapter VIII, Section 2. All papers read before the Association shall become its property. Each paper shall be deposited with the Secretary when read, and if this is not done it shall not be published.

No miscellaneous or business matters will be discussed before the scientific meetings, but will be referred to the House of Delegates.

We are instructed by the President to announce to all essayists that the sessions of the Scientific Program of the Association will begin on time, and that the above regulations of the By-Laws in reference to the program will be strictly enforced.

COMMITTEE ON SCIENTIFIC WORK

W. C. McGeary, Chairman	Madison
Richard Torpin	Augusta
Thomas L. Ross, Jr.	Macon
Edgar D. Shanks	Atlanta

GEORGIA PHYSICIANS WHO HAVE PRACTICED MEDICINE FIFTY YEARS

Belcher, Fannin S., Savannah
 Boyd, James M., Douglasville
 Bradley, Thos. E., Fitzgerald
 Brewer, Asbury M., Tunnel Hill
 Broadrick, Geo. L., Dalton
 Chason, Gordon, Bainbridge
 Collins, Joshua C., Collins
 Colson, Algernon C., Glennville
 Cooke, Wm. Lawrence, Columbus
 Copeland, Henry W., Griffin
 Forrer, Daniel Atwell, Griffin
 Funke, John, Atlanta
 Hodgson, Fred G., Atlanta
 Isbell, Jesse E. D., Toccoa
 Maner, Wm. Albert, Douglasville
 Maxwell, Counsel H., Calvary
 McCurry, Wm. Edgar, Hartwell
 Mitchell, Frank B., Metter
 Mixson, Joyce F., Valdosta
 Murray, Geo. S., Columbus
 Person, Weldon E., Atlanta
 Rogers, Wm. Hershel, Youngcane
 Rouglin, Louis C., Atlanta
 Schenck, Herbert C., Atlanta
 Silveus, Elmer O., Atlanta
 Stukes, Jos. T., Americus
 Veale, Emory O., Sr., Arnoldsville
 Weaver, John C., Atlanta
 Williams, Virgil G., Grantville
 Willson, Pleas, Newborn

IN MEMORIAM

Adams, Bentley Childs, Thomaston, August 28, 1950, aged 53.
 Auten, Will James, Atlanta, December 25, 1950, aged 85.
 Bashinski, Benjamin, Macon, May 20, 1950, aged 64.
 Blackman, Wave Wilbur, Atlanta, June 16, 1950, aged 69.
 Bowcock, Harold Mathew, Dallas, Texas, November 29, 1950, aged 92.
 Bridges, Judge J., Atlanta, July 25, 1950, aged 81.
 Brooks, Henry W., Sr., Buena Vista, June 28, 1950, aged 56.
 Butler, James Harvey, Augusta, June 8, 1950, aged 56.
 Campbell, William Harold, Columbus, August 10, 1950, aged 84.
 Casteel, Lewis R., Washington, April 2, 1950, aged 82.
 Daniel, Charles Howard, College Park, April 17, 1950, aged 50.
 Darden, Horace, Sparta, November 16, 1950, aged 92.
 Ellis, John W., Kennesaw, December 17, 1950, aged 82.
 Enzor, Roscoe Hinson, Sr., Smithville, April 12, 1950, aged 62.
 Etheridge, William Maxey, Atlanta, February 4, 1951, aged 78.
 Farbar, Marian E., Valdosta, May 4, 1950, aged 69.
 Fletcher, Carlton C., Moultrie, June 25, 1950, aged 53.
 Freeman, Edward Rutledge, Columbus, July 22, 1950, aged 34.
 Gaines, Thomas Hirman, Elberton, September 13, 1950, aged 73.

Gay, James Gaston, Atlanta, January 22, 1951, aged 53.
 Gerdine, John, Jersey, June 13, 1950, aged 75.
 Giuffrida, Frank J., Sr., Atlanta, December 21, 1950, aged 70.
 Giddings, Charles Glenville, Sr., Atlanta, February 24, 1951, aged 89.
 Green, Thomas E., Chatsworth, January 21, 1951, aged 72.
 Hess, George, Atlanta, May 12, 1950, aged 49.
 Holbrook, William H., Atlanta, September 8, 1950, aged 75.
 Howell, Jesse Lee, Atlanta, April 25, 1950, aged 59.
 Hull, Marion McHenry, Atlanta, March 28, 1950, aged 78.
 Hutcheson, Edward Bailey, Buchanan, May 12, 1950, aged 93.
 Iseman, Everette, Savannah, September 3, 1950, aged 65.
 Jelks, Edwin Lankin, Quitman, April 27, 1950, aged 76.
 Johnson, Joseph E. L., Roberta, June 29, 1950, aged 82.
 Liles, Homer D., Flowery Branch, October 20, 1950, aged 61.
 Lowe, William Robert, Midville, November 13, 1950, aged 65.
 Lower, Emory Galen, Atlanta, July 25, 1950, aged 47.
 Maulding, Homer R., Atlanta, March 3, 1951, aged 42.
 McCall, John Turner, Sr., Rome, February 11, 1951, aged 68.
 McDougall, William Lowndes, Atlanta, July 18, 1950, aged 57.
 McDuffie, James Henry, Columbus, September 27, 1950, aged 62.
 Richards, William Roy, Calhoun, March 23, 1950, aged 59.
 Riley, Julian G., Atlanta, January 12, 1951, aged 51.
 Ripley, E. C., Decatur, October 25, 1950, aged 81.
 Ritch, Thomas Green, Jesup, February 12, 1951, aged 60.
 Roundtree, Walter, Summit, January 5, 1951, aged 79.
 Saliba, John, Savannah, November 16, 1950, aged 81.
 Scales, Seaborn F., Carrollton, June 24, 1950, aged 65.
 Shepard, William Marshall, Adel, April 26, 1950, aged 81.
 Slocumb, Clyde B., Doerun, October 29, 1950, aged 63.
 Smith, Claude A., Stockbridge, February 8, 1951, aged 78.
 Smith, Marvin F., Atlanta, January 30, 1951, aged 72.
 Strickland, James Oscar, Pembroke, July 11, 1950, aged 72.
 Tatum, P. A., Columbus, February 2, 1950, aged 68.
 Ward, Charles D., Augusta, October 12, 1950, aged 60.

SCIENTIFIC EXHIBITS

Partridge Inn

1. *Plastic Surgery*—Department of Plastic Surgery, Medical College of Georgia, W. S. Flanagan, Augusta.
2. *Medical History*—J. Calvin Weaver, Atlanta.
3. *Viral Hepatitis*—Department of Medicine, Medical College of Georgia, N. Reeves, C. L. Leedham, and V. P. Sydenstricker, Augusta.
4. *Manikin Teaching of Obstetrics and Gynecology*—Department of Obstetrics and Gynecology, Medical

College of Georgia, Richard Torpin, and Staff, Augusta.

5. *Obstetric Seminar*—Sponsored by the Divisions of Maternal and Child Health of the State Boards of Health of Georgia, Florida and South Carolina. Mrs. Logan Curry, Local Secretary.
6. *Fulvar Luminescence*—Department of Medical Illustrations, A. O. Parkes, and Department of Endocrinology, Medical College of Georgia, Robert B. Greenblatt, Augusta.
7. *Functional Disorders Associated with Carcinoma of the Cervix Uteri and its Cyto-Diagnostic Problems*—Department of Clinical Cytology, Medical College of Georgia, H. E. Nieburgs and S. Bamford, Augusta.
8. *Results of Prolonged ACTH Therapy (7.945 mg.) in a Patient with Pan-Hypopituitarism*—Department of Endocrinology, Medical College of Georgia, Nelson H. Brown, Sarah L. Clark, and M. L. Moss, Augusta.
9. *Obesity*—State of Georgia Department of Public Health, Maternal and Child Health Division, Atlanta.
10. *For Your Baby's Happiness, For Your Happiness*—State of Georgia Department of Public Health, Mental Hygiene Division, Atlanta.
11. *Bentyl Hydrochloride: A New Antispasmodic*—Department of Medicine, Medical College of Georgia, C. W. Hock, Augusta.
12. *Expansion of Hospital Facilities in Georgia*—State of Georgia Department of Public Health, R. C. Williams, Atlanta.

MOVIES

Partridge Inn

1. *A Technique for Hemorrhoidectomy with Cryptectomy and Posterior Proctomy*—Edgar Boling, Department of Surgery, Proctology Section, Emory University School of Medicine, Atlanta. Approximate running time: 15 minutes.
2. *Surgery of the Shoulder*—Paul T. Reith, and E. B. Dunlap, Jr., Department of Orthopedics, Emory University School of Medicine, Atlanta. Approximate running time: 15 minutes.
3. *Operation for Coarctation of the Aorta*—Osler A. Abbott, and William A. Hopkins, Department of Thoracic Surgery, Emory University School of Medicine, Atlanta. Approximate running time: 15 minutes.
4. *Perineal Prostatectomy for Benign Enlargement of the Prostate*—James H. Semans, Department of Urology, Emory University School of Medicine, Atlanta. Approximate running time: 15 minutes.
5. *Laryngectomy*—Lester A. Brown, and Staff, Department of Otolaryngology, Lawson VA Hospital (in conjunction with Emory University School of Medicine), Atlanta. Approximate running time: 25 minutes.
6. *The Detection and Diagnosis of Cancer of the Cervix Uteri*—H. E. Nieburgs, E. R. Pund, and S. Bamford, Departments of Clinical Cytology and Pathology, Medical College of Georgia, Augusta. Approximate running time: 30 minutes.
7. *The Physiologic Basis for the Action of ACTH in Human Beings*—R. B. Greenblatt, Department of Endocrinology, Medical College of Georgia, Augusta. (Courtesy of Armour Laboratories). Approximate running time: 45 minutes.
8. *The Therapeutic Use of ACTH in Human Disease*—R. B. Greenblatt, Department of Endocrinology, Medical College of Georgia, Augusta. (Courtesy of Armour Laboratories). Approximate running time: 33 minutes.

TECHNICAL EXHIBITS

Bon Air Hotel

1. Van Pelt and Brown, Inc.
Richmond, Virginia
2. Wm. P. Poythress & Co., Inc.
Richmond, Virginia
3. Lederle Laboratories Division
American Cyanamid Company
30 Rockefeller Plaza, New York 20, New York
6. Augusta Bedding Company
922-30 Eighth Street, Augusta, Georgia
7. Philip Morris & Co. Ltd., Inc.
100 Park Avenue, New York 17, New York
14. Sandoz Pharmaceuticals
Division of Sandoz Chemical Works, Inc.
68-72 Charlton Street, New York 14, New York
15. Testagar & Co., Inc.
638 Bagley Avenue, Detroit 26, Michigan
16. Eli Lilly and Company
Indianapolis 6, Indiana
17. Parke, Davis & Company
Detroit 32, Michigan
Mr. C. O. Church, 252 Courtland St., N. E., Atlanta, Georgia
19. Winthrop-Stearns Inc.
1450 Broadway, New York 18, New York
20. A. H. Robins
1322-24 West Broad Street, Richmond, Virginia
21. Marks Surgical Supplies, Inc.
1429 Harper Street, Augusta, Georgia
22. Brayten Pharmaceutical Company
Chattanooga 8, Tennessee
Mr. Ben Perryman, P. O. Box 242, Atlanta, Ga.
23. Mead Johnson & Company
Evansville 21, Indiana
Mr. J. H. Gilmore, 1672 Emory Road, N. E., Atlanta, Georgia
24. C. B. Fleet Company, Inc.
921-927 Commerce Street, Lynchburg, Virginia
25. E. R. Squibb & Sons
745 Fifth Avenue, New York 22, New York
26. Baby Development Clinic
1027 Merchandise Mart, Chicago 54, Illinois
28. The Robertson Statement—Handling System
Atlanta, Georgia
29. The Doho Chemical Company
100 Warwick Street, New York 13, New York
31. General Electric X-ray Corporation
1383 Spring Street, N. W., Atlanta, Georgia
39. Picker X-Ray Corporation
300 Fourth Avenue, New York 10, New York
41. Hoffmann-La Roche, Inc.
Roche Park, Nutley 10, New Jersey
42. The Liebel-Flarsheim Company
Cincinnati 2, Ohio
43. Ciba Pharmaceutical Products, Inc.
556 Morris Avenue, Summit, New Jersey
45. U. S. Vitamin Corporation
250 East 43rd Street, New York 17, New York
46. Sharp & Dohme, Inc.
Philadelphia 1, Pennsylvania

CONSTITUTION AND BY-LAWS OF THE MEDICAL ASSOCIATION OF GEORGIA, 1951

Constitution

ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be The Medical Association of Georgia.

ARTICLE II.—PURPOSES OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one component organization the entire medical profession of the State of Georgia; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the material interests of its members and to protect them against imposition; and to enlighten and direct public opinion in regard to the great problems of state and medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county societies which hold charters from this Association.

ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1. This Association shall consist of members and delegates.

Sec. 2. Members: The members of this Association shall be the members of the component county medical societies to which only white physicians shall be eligible.

Sec. 3. Delegates: Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.

ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Association, and shall consist of: (1) delegates elected by the component county societies; (2) the officers of the Association enumerated in Section 1 of Article IX of the Constitution; (3) ex-presidents, and delegates to the American Medical Association.

ARTICLE VI.—COUNCIL

The Council shall be the Board of Trustees and Finance Committee of the Association. The Council shall have full authority and power of the House of Delegates to be called into session as provided in the Constitution and By-Laws.

It shall consist of the Councilors, the President, the President-Elect and the Secretary-Treasurer of the Association. Five of its members shall constitute a quorum.

ARTICLE VII.—SESSIONS AND MEETINGS

Section 1. The annual session shall take place on the second Wednesday in May at such place as shall be designated by the Association, provided that in case of conflict with the annual session of the American Medical Association or on petition of the county society of the host city made at least six months before the fixed dates for the annual session, the Council may change the dates

by publishing a notice in the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA three months before the session.

Sec. 2. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Council, or upon the petition of twenty delegates.

ARTICLE VIII.—SECTIONS AND DISTRICT SOCIETIES

Section 1. The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections, and for the organization of such Councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE IX.—OFFICERS

Section 1. The officers of this Association shall be a President, President-Elect, two Vice-Presidents, a Secretary-Treasurer, a Parliamentarian, and one Councilor for each congressional district in the State.

Sec. 2. The officers, except the Secretary-Treasurer, Parliamentarian and Councilors, shall be elected annually, provided that after the annual meeting of 1928 a President-Elect and not a President shall be elected annually. The President-Elect shall assume his office as President immediately after the next annual meeting following his election. The terms of the Councilors shall be for three years, as may be arranged, viz: the Councilor for the first, second, third and fourth districts for three years; those for the fifth, sixth, seventh, and eighth districts for one year; those for the ninth and tenth districts for two years. The Secretary-Treasurer shall be elected for a term of five years, and the Parliamentarian for a term of three years. All these officers shall serve until their successors are elected and installed (1933).

Sec. 3. The officers of this Association shall be elected by ballot. The nomination for office shall be made orally, on the first day of the annual session immediately after the response to the address of welcome and just before the first paper of the scientific program. The nominating speech shall not exceed two minutes.

The Councilors shall be nominated at the same time by their respective district societies, but if no nomination from a district society is brought before the Association, the nomination for Councilor may be presented from the floor.

A locked ballot box shall be set up by 12:00 noon of the first day of the annual scientific session, at the registration booth. Official ballots, with a blank space for writing in the name of the candidate for each office, shall be printed and kept in the custody of the Secretary-Treasurer, who shall check the eligibility of each voter before handing him an unnumbered ballot. Votes shall be deposited in the locked ballot box.

Voting shall take place during the hours the scientific program is in session, from 12:00 noon on the first day of the annual session until 10:30 a.m. of the third day of the annual session. A committee, appointed by the President, shall count the votes in the ballot box at 10:30 a.m. of the last day of the annual session and report their findings to the Association. The candidate

receiving the highest number of votes shall be declared elected.

Delegates to the American Medical Association shall be elected at the same time and in the same manner.

ARTICLE X.—FUNDS AND EXPENSES

Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall not exceed the sum of \$35.00 per capita per annum. Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be approved by the Finance Committee before action is taken thereon.

ARTICLE XI.—RATIFICATION

The House of Delegates shall submit all questions before it to the Association for ratification.

ARTICLE XII.—THE SEAL

The Association shall have a common seal, with power to break, change or renew the same at pleasure.

ARTICLE XIII.—AMENDMENTS

Any amendment that may be offered to the Constitution shall lie over until the next annual session; and for its adoption at such session shall require a two-thirds vote of all present and voting.

By-Laws

CHAPTER I.—MEMBERSHIP

Section 1. The name of a physician on the properly certified roster of members of a component society, which has paid its annual assessment, shall be *prima facie* evidence of membership in this Association.

Sec. 2. Any person who is under sentence of suspension or expulsion from a component society or whose name has been dropped from its roll of members, shall not be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Sec. 3. Each member in attendance at the annual session shall enter his name on the registration book, indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section.

Sec. 4. Special membership. In addition to *Regular* members, component societies may elect to membership in their organizations, for membership in this Association, the following groups of members:

(a) *Honorary members.* Any member for old age, length of service, or other good reasons, may be elected an honorary member of his county medical society, for membership in this Association. Such member shall, after election, be issued a certificate of honorary membership in this Association.

Non-resident physicians and resident or non-resident lay persons who have distinguished themselves in fields of endeavor devoted to the advancement of human wel-

fare, may be nominated by county medical societies, or by the House of Delegates of this Association, for honorary membership in this Association. A county medical society shall not nominate for this class of membership more than one person each year. The name of such person shall be sent to the Secretary-Treasurer of this Association thirty days in advance of the annual session. Such person shall be issued an appropriate certificate of honorary membership in this Association if, and when, he is elected to honorary membership by this Association.

(b) *Associate members.* Eligible to this classification are (1) those regular members of component societies to whom the payment of dues would be an undue hardship; (2) interns, and (3) commissioned medical officers (see Chapter VII, Sec. 5 of these By-Laws) of the United States Army, the United States Navy and the United States Public Health Service while engaged actively in their respective services or if they have been retired on account of age or physical disability, or after long and honorable service, under the provisions of an Act of Congress.

(c) Honorary and Associate members shall not be subject to the payment of dues to the State Association. They shall enjoy the privileges of full participation in the scientific, social and educational activities of this Association. They shall not vote nor hold office and do not receive the JOURNAL or benefits of Medical Defense.

Sec. 5. Any physician applying for membership in a component medical society of this Association, who has previously practiced in a county in which affiliation with a component society is provided, and who moves to another county without having affiliated with the medical society in the jurisdiction of previous residence, before he is admitted to membership, the cause of his lack of affiliation in the society of his previous residence shall be ascertained.

CHAPTER II.—GENERAL MEETINGS

Section 1. All registered members may attend and participate in the proceedings and discussions of the general meetings. Visitors duly accredited to represent the associations of other states, or of the District of Columbia, not exceeding two in number for each organization, may attend upon, and participate in, the discussion of the general meeting, but shall not have a vote. Such delegates may read papers upon invitation of the Committee on Scientific Work. The general meetings shall be presided over by the President or by one of the Vice-Presidents.

Sec. 2. No papers or addresses before the Association, except those of the President and invited essayists, shall occupy more than fifteen minutes in their delivery; and no member shall speak longer than five minutes, nor more than once on any subject, provided that each essayist shall have five minutes in which to close the discussion of his paper.

Sec. 3. Entertainment. Any social entertainment which may be given by this Association shall be confined to the evening of the second day.

Sec. 4. *Guests.* Any physician not a resident of this State but a member of his state association, or any distinguished scientist not a physician, may be counted

a guest during any annual session on invitation of the President, and shall be accorded the privilege of participating in the scientific work of that session.

CHAPTER III.—HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet on the day preceding the first day of the annual session, the time to be fixed by the Committee on Scientific Work. It may adjourn from time to time as may be necessary to complete its business; provided that its hours shall conflict as little as possible with the general meetings. The order of business shall be arranged as a separate section of the program.

Sec. 2. Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members, and one for each fraction thereof, but each component society which has made its annual report and paid its assessment as provided in this Constitution and By-Laws shall be entitled to one delegate. Should the regular delegates from any county not be present at the meeting, the President shall appoint a substitute from that county to act.

Sec. 3. Twenty delegates present shall constitute a quorum.

Sec. 4. It shall, through its officers, council and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping-stone to future ones of higher interest.

Sec. 5. It shall consider and advise as to the material interest of the profession, and of the public in those important matters wherein it is dependent on the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.

Sec. 6. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest of such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality, and shall continue these efforts until, if possible, every physician in every county of the State has been brought under medical society influence.

Sec. 7. It shall encourage post-graduate and research work as well as home study, and shall endeavor to have the results utilized, and intelligently discussed in the county societies.

Sec. 8. It shall divide the State into councilor districts, one for each congressional district, and when the best interests of the Association and profession will be promoted thereby, organize in each a district medical society, and all members of component county societies and no others shall be members in such district societies.

Sec. 9. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such committees shall report to the House of Delegates and may be present and participate in the debate thereon.

CHAPTER IV.—DUTIES OF OFFICERS

Section 1. The President shall preside at all meetings of the Association and of the House of Delegates; shall appoint all committees not otherwise provided for, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and as far as practicable, shall visit, by appointment, the various sections of the State and assist the Councilors in building up the county societies, and in making their work more practical and useful.

In order to give him a better opportunity of becoming more fully acquainted with his duties and with the needs of the Association, the President shall be elected one year prior to taking office. During this time he shall be known as President-Elect and shall be ex-officio member of standing committees, and shall make recommendations at the next annual session.

Sec. 2. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of the President's death, resignation or removal, the Vice-Presidents, in their order, shall succeed him.

Sec. 3. The Secretary-Treasurer shall give bond in the sum of One Thousand Dollars. He shall demand and receive all funds due the Association, together with the bequests and donations.

Sec. 4. The Secretary-Treasurer shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep the minutes of their respective proceedings in separate record books. He shall be ex-officio Secretary of the Council. He shall be custodian of all record-books and papers belonging to the Association. He shall provide for the registration of the members, delegates and accredited visitors at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and on request transmit a copy of this list to the American Medical Association. He shall aid the Councilors in the organization and improvement of the county societies in the extension of the power and usefulness of this Association. He shall conduct the official correspondence, notifying members of meetings, officers of their election, and committees of their appointments and duties. He shall employ such assistants as may be ordered by the House of Delegates with the approval of the Association, and shall make an annual report to the Association. He shall supply each component society with the necessary blanks for making their annual reports; shall keep an account with the component societies, charging against each society its assessment and collect the same. Acting with the Committee on Scientific Work, he shall prepare and issue all programs. The amount of his salary shall be fixed by the Association. He shall be editor of the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA. He shall employ such assistants as may be ordered by the Council or the House of Delegates. He shall annually make a report of his doings to the House of Delegates.

He shall furnish a balance sheet at each annual meeting for the past fiscal year to be published in the JOURNAL. This shall consist of an itemized statement of all financial transactions of the past year, all accounts made, money received and from whom, all moneys disbursed, to whom, and for what purpose, with vouchers attached. A fiscal year includes the period of time between the first day of May and the last day of April.

CHAPTER V.—COUNCIL

Section 1. The Council shall meet on the day preceding the annual session and daily during the session, and at such other times as necessity may require, subject to the approval of the President. It shall meet on the last day of the annual session of the Association to organize and outline work for the ensuing year. It shall elect a chairman and clerk, who, in the absence of the Secretary of the Association, shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the House of Delegates. It shall be the business body of the Association and attend to the business of the Association in the interim between meetings.

Sec. 2. Each Councilor shall be organizer and peace-maker for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the conditions of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The necessary traveling expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the House of Delegates on a properly itemized statement, but this shall not be considered to include his expense in attending the annual session of the Association. Each Councilor may appoint a Vice-Councilor to assist him in the performance of his duties in his district.

Sec. 3. The Council shall be the board of censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to the members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of a component society, on which an appeal is taken from the decision of an individual Councilor, or to which attention has been called by the Councilor or interested members. It shall hear and decide all questions affecting unethical conduct on the part of any member of any annual session, and its decision in all such matters shall be final when ratified by the Association.

Sec. 4. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies, and the societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec. 5. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Association, and shall have authority to appoint such assistants to the editor as it deems necessary. It shall manage and conduct the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, which is the organ of the Association, and all money paid into the treasury as dues shall be received as subscriptions to the JOURNAL.

All money received by the Council and its agents, resulting from the discharge of the duties assigned to them, must be paid to the Secretary-Treasurer of the Association. As the Finance Committee it shall annually audit the accounts of the Secretary-Treasurer and other agents of this Association, and present a statement of the same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of the Association during the year, and the amount of all other property belonging to the Association under its control, with such suggestions as it may deem necessary. In the event of a vacancy in the office of the Secretary-Treasurer, the Council shall fill the vacancy until the next annual election.

Sec. 6. All reports on scientific subjects and all scientific discussions and papers heard before the Association, shall be referred to the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA for publication. The editor, with the consent of the Councilor for the district in which he resides, may curtail or abstract papers or discussions, and the Council may return any paper to its author which it may consider not suitable for publication.

Sec. 7. All commercial exhibits during the annual sessions shall be within the control and direction of the Council.

Sec. 8. In the absence of a Councilor and Vice-Councilor the President is empowered to appoint a representative from the district as acting Councilor, who shall have full rights and powers of a Councilor.

Sec. 9. Each Councilor shall render at every session a written report of each county in his district.

Sec. 10. Any member of the Council who fails to attend two regular successive sessions of the Council, or whose district does not show evidence of the performance of his duties during the year, unless he renders an acceptable excuse to the Council, is subject to have his position declared vacant by the President and a successor appointed by the President.

CHAPTER VI.—COMMITTEES

Section 1. The standing committees shall be as follows:

A Committee on Scientific Work.

A Committee on Public Policy and Legislation.

A Committee on Arrangements.

A Committee on Medical Defense, and such other committees as may be necessary.

Sec. 2. The Committee on Scientific Work shall consist of four members, one of whom shall be the Secretary-Treasurer. The other three members shall be appointed for terms of one, two, and three years, respectively. The vacancy which will occur each year by the expiration of the term of one member shall be filled by the President

with an appointment of three years. The member who has the shortest time to serve shall be chairman. The committee shall determine the character and scope of the scientific proceedings of the Association for each session. Thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers, discussions and other business shall be presented.

This By-Law shall not prohibit the Committee on Scientific Work from inviting not more than two distinguished members of the national organization to deliver addresses or read papers at any annual meeting.

Sec. 3. The Committee on Public Policy and Legislation shall consist of three members and the President and Secretary, the Commissioner of Health of the State of Georgia, and a sub-committee of three members from each Councilor District appointed by the chairman when needed. It shall represent the Association in securing and enforcing legislation in the interests of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local and national affairs and elections.

Sec. 4. The Committee on Arrangements shall be appointed by the component society in which the annual session is to be held. It shall provide suitable accommodations for the meeting places of the Association and of the House of Delegates and their respective committees, and shall have general charge of all arrangements. Its chairman shall report an outline of the arrangements to the Secretary-Treasurer for publication in the program, and shall make additional announcements during the session as occasion may require.

Sec. 5. The Committee on Medical Defense shall consist of five members, of whom the Chairman of the Council and the Secretary-Treasurer of the Association shall be members. The other members, one of whom shall act as chairman of the committee, shall be elected by the Council for a period of five years. Those elected at this meeting (April 19, 1916), shall serve one, three and five years, respectively.

It shall be the duty of the Committee on Medical Defense to investigate and defend all damage suits against the Medical Association of Georgia; to investigate all claims of civil malpractice made against its members, to take full charge of such cases, which after investigation they decide to be proper cases for defense; to defend all such cases in the courts of last resort, to furnish General Counsel and pay court cost usual to such litigation, and reasonable fees for local attorneys as shall be arranged by General Counsel. Provided that any member who has indemnity insurance shall have such insurance bear its portion of the expense. However, they shall not pay, or obligate the Medical Association of Georgia to pay any judgment rendered against any member upon the final determination of any case. They shall be empowered to contract with such agents or attorneys as they may deem necessary for the proper carrying out of this By-Law.

The assistance for defense, as herein provided, shall be

available only to members of the Medical Association of Georgia in good standing. Any member who has not paid his annual dues by April 1st shall not be considered in good standing in the application of this By-Law.

Any member or members of the Association threatened with suit for civil malpractice shall immediately communicate with the Secretary of the Association and shall give full and complete information in reference to all the circumstances alleged in the complaint. The Secretary shall proceed immediately to investigate the circumstances reported and shall advise with the attorneys or agents employed by the committee for this purpose. The member sued, or threatened with suit, shall be consulted and shall have the complete confidence of the committee in all transactions connected with the investigation in question. The committee shall have the authority to require of a constituent society or the president thereof, the appointment of a committee of investigation in any such case, and it may direct the committee so appointed to report to the Committee on Medical Defense and not to the society from which it was appointed.

The Committee on Medical Defense may also, at its discretion, arrange to prosecute illegal practitioners in the State of Georgia and assist in the enforcement of the Medical Practice Act of this State.

CHAPTER VII.—COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Association, or those which may hereafter be organized in the State, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, on application, receive a charter from and become a component part of this Association.

Sec. 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the State in which no component society exists, and charter shall be issued thereto.

Sec. 3. Charters shall be issued only on approval of the Council, and shall be signed by the President and Secretary of this Association. The Association shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Sec. 4. Only one component medical society shall be chartered in any county.

Sec. 5. Each county society shall judge of the qualifications of its own members, but as such societies are the only portals to this Association, every legally registered white physician who does not practice or claim to practice, nor lend his support to any exclusive system of medicine, shall be eligible to membership. Physicians who have been legally registered in other states or who have been licensed by the National Board of Medical Examiners, or who are employed as teachers in the medical schools, or are in the service of the State, a county, a municipality, or the United States Government other than the regular medical corps of the United States Army, the United States Navy and of the United States Public Health Service, may be accepted for membership in county medical societies, for membership in this Association, provided they meet the requirements

of regular membership. Before a charter is issued to any county medical society, full and ample notice and opportunity shall be given to every such physician in the county to become a member.

Sec. 6. No matter what the unethical conduct or discipline of the members of the county society may be, both plaintiff and defendant shall have the right to appeal to the Council, whose decision shall be final when ratified by the Association.

Sec. 7. In hearing appeals the Council may admit oral or written evidence, as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 8. When a member in good standing in a component county society moves to another county in this State, he shall be given a written certificate of these facts by the Secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he moves, such member shall be considered to be in good standing in the county society from which he was certified and in the Medical Association of Georgia to the end of the period for which his dues have been paid.

Sec. 9. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in which jurisdiction he resides.

10. Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county; and systematic efforts shall be made by each member and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Sec. 11. At some meeting in advance of the annual session of this Association each county society shall elect a delegate or delegates to represent it in the House of Delegates of this Association, in the proportion of one delegate to each fifty members, or fraction thereof, and the Secretary of the society shall send a list of such delegates to the Secretary of this Association at least ten days before the annual session.

Sec. 12. The Secretary of each component society shall keep a roster of its members, and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. In keeping such roster the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Sec. 13. The Secretary of each component society shall forward its assessment, together with its roster of officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary of

this Association each year thirty days before the annual session.

Sec. 14. Any county society which fails to pay its assessment, or make the report required on or before April 1 of each year, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association, or of the House of Delegates, until such requirement has been met.

Sec. 15. The Secretary of each county society shall report to the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

CHAPTER VIII.—RULES AND ETHICS

Section 1. The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and By-Laws.

Sec. 2. All papers read before the Association shall become its property. Each paper shall be deposited with the Secretary when read, and if this is not done it shall not be published.

Sec. 3. The principles of medical ethics of the American Medical Association shall be those of this Association.

Sec. 4. Any member of this Association, on locating in a new place for practicing his profession, may place his professional card, containing name, address, telephone number, and statement as to whether or not his practice will be limited to any particular class of diseases, in the local paper for a period of not longer than one month. The placing of such card for this period of time shall not be considered unethical. The use of the word "specialist" by any member in connection with his name in any newspaper, telephone directory, or other public places, shall be considered unethical.

CHAPTER IX.—AMENDMENTS

These By-Laws may be amended at any annual session by a majority vote of the Association after the amendment has lain on the table for one day.

HEALTHGRAMS

Modern public health does not prevent death alone. It also prevents disease. For every life preserved by a tuberculosis program, scores of individuals are saved from invalidism. For every life saved from malaria, hundreds of individuals are maintained as active producers in the population. Ed., Am. J. Pub. Health, August, 1950.

* * *

As a rule, elevation of temperature without adequate explanation should cause one to suspect pulmonary tuberculosis early in the differential study. The stethoscope has no place in the diagnosis of early tuberculosis, and the sooner physicians realize this fact, an increase in diagnosed cases of tuberculosis will become apparent. Physical signs are far less valuable than the roentgen examination in the recognition of early pulmonary tuberculosis. Inevitable failures in the detection of pulmonary lesions and the interpretation of their nature are not uncommon when reliance is placed on this method alone, this in spite of the greatest care and experience in the performance of physical examinations. GP, Am. Acad. of General Practice, F. Kenneth Albrecht, April, 1950.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

DIABETES CASE FINDING IN GEORGIA

LESTER M. PETRIE, M.D.*

and

RICHARD H. FETZ**

Atlanta

The decrease in the incidence of communicable diseases during the past few decades has focused the attention of the medical profession and public health authorities more and more on the early detection of the degenerative diseases of the older age groups. Members of the profession recognize that the early detection of such conditions as heart disease, cancer, nephritis, arteriosclerosis, and diabetes facilitates treatment and increases the possibility of cure.

The vast importance of this problem is readily understood when it is realized that these degenerative conditions account for over one-half of the deaths in this country today¹. Furthermore, from the standpoint of the community the individual whose illness is discovered early is less likely to become a financial burden at some future time. To the individual, aside from saving him some serious illness, he is saved loss of earning power. The physician also benefits when a patient seeks medical care before he reaches that financial stage when he must be a "charity" patient.

Numerous studies have been made concerning the incidence rates of diabetes and all statistics seem to agree that there are at least one million latent and undiagnosed cases of diabetes in the United States today². If the incidence rate of 20 per 1,000 individuals³ is applied to the three-million-plus population of Georgia, we find that there should be in the neighborhood of 66,000 people with diabetes in our State. Most of these individuals are still unaware of their diabetic condition.

In the past the responsibility for the detection of diabetes rested almost entirely with the general practitioner. He has been fortunate lately in having the assistance of diabetes detection drives sponsored by the American Diabetes Association in cooperation with the American Medical Association. It is unfortunate, however, that such detection campaigns have touched only a small segment of the population of our State and that of the country as a whole.

The inadequacy of the diabetes detection program in Georgia was forcefully brought to the attention of the Georgia Department of Public Health by Dr. J. Edgar Paullin at a meeting of the State Board of Health in 1949. Dr. Paullin

put forth the idea that a diabetes detection drive similar to that provided for tuberculosis and venereal disease could and should be incorporated into the county-wide screening programs which the Georgia Department of Public Health in conjunction with local and county health departments has been carrying on since 1945^{4,5}. The basic concepts of the proposed program were quickly formulated and approved by the Medical Association of Georgia and steps were taken to add this feature to the case finding surveys, provided the necessary technical details could be solved.

It was imperative that a simple, accurate, and rapid method for the determination of abnormal carbohydrate metabolism be provided. Study seemed to indicate that it would be feasible to incorporate a blood sugar method into the survey procedure, inasmuch as blood was being withdrawn from each individual for standard serologic tests for syphilis. Further investigation proved that the recently developed Anthrone method^{6,7} would be suitable for this work.

The first trials of this new technic were carried out in Twiggs and Lowndes counties in small scale industrial surveys in late 1949. The early trials proved so successful that the test was approved by the Fulton County Medical Society for inclusion in the Greater Atlanta Health Survey carried out from April to July, 1950. The procedure, further refined and of increased sensitivity, has now been integrated with the continuing county-wide screening programs, and as of today more than three hundred thousand individuals have been screened for abnormality of sugar metabolism by the Georgia Department of Public Health.

From the beginning it was necessary to set up diabetes case finding standards for multiphasic screening. A committee on standards representing the Fulton County Medical Society and the Medical Association of Georgia was established. It was realized at an early date that the standards would have to have some degree of flexibility, inasmuch as there would be no control over the previous diet or time of food intake when an individual came through a survey station. Experience in the Atlanta survey demonstrated that certain portions of the histories as obtained at the time of a survey are unreliable—too many applicants fail to remember having partaken of food or drink during the preceding four hours. Referral to physicians for sugar tolerance tests of this large number of normal people is an unnecessary and wasteful nuisance, both to the patient and to his physician. The advisory committee of the Medical Association was in agreement with this opinion. These facts have been taken into consideration in setting up standards

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** Chemist-in-Charge, Diabetes Survey Laboratory, Georgia Department of Public Health, Atlanta.

for referral of individuals found to be abnormal. In order to facilitate reporting, five broad groups or blood sugar ranges have been established into which all individuals are placed depending upon the results of their blood sugar screen tests. These groups are as follows:

Group I—Those individuals whose blood sugar levels are less than 130 mg. per 100 cc. of blood at the time of venipuncture.

Group II—Those individuals whose blood sugar levels range between 130 mg. and 170 mg. per 100 cc. of blood at the time of venipuncture and *who have* consumed food within the two hour period preceding the test.

Group IIR—Includes those individuals whose blood sugar levels range between 130 mg. and 170 mg. per 100 cc. of blood at the time of venipuncture and *who have not* consumed any food within the two hour period preceding the test.

Group III—Includes those individuals whose blood sugar levels range between 170 mg. and 200 mg. per 100 cc. of blood at the time of venipuncture regardless of the time since the last intake of food.

Group IV—Includes those individuals whose blood sugar levels exceed 200 mg. per 100 cc. of blood at the time of venipuncture regardless of time since the last intake of food.

Individuals are notified by mail that their blood sugar test appears to be within normal limits unless the findings exceed the following limits:

A. All individuals, regardless of time since last intake of food, whose blood sugar exceeds 170 mg. sugar per 100 cc. blood. (Groups III-IV).

B. Individuals whose last intake of food preceded the test by more than two hours and whose blood sugar exceeds 130 mg. sugar per 100 cc. blood. (Group IIR).

Individuals included in A or B above are asked to report to the testing station in a fasting condition for confirmatory testing of the blood sugar level following the oral administration of a known quantity of glucose.

Reports to individuals and their physicians are classified as follows:

ABNORMAL: Individuals whose blood sugar level is 170 mg. per 100 cc. or over two hours after the glucose intake.

BORDERLINE: Individuals whose blood sugar level is 170 mg. per 100 cc. or over during the two hours but is below 170 mg. per 100 cc. at the end of the two hours.

NORMAL: (1) *On Original Screen Test*—Individuals below 130 mg. per 100 cc. blood. Individuals between 130 and 170 mg. per 100 cc. blood when tested within two hours following food consumption. (2) *On Glucose Tolerance Test*—Individuals not exceeding 170 mg. per 100 cc. at any time during the two hours.

Individuals classified as *abnormal* or *borderline* are notified that they may have an abnormal sugar metabolism and are urged to see their personal physician and are given a copy of their findings that they may take to him. Individuals classified as *normal* are notified accordingly.

Our experiences today indicate that approximately 90-95 per cent of the individuals screened will fall within Group I on the initial screen test. Approximately 3-8 per cent will fall into Groups II or IIR and approximately 4/5 of these individuals will have partaken of food within the last 2 hours and are, therefore, considered normal. About 1-2 per cent of all individuals screened will be found either in Group III or IV. These percentages vary with the race, age groups and sex of the people being tested.

Some time ago it became evident as a result of polls of physicians that many of the individuals behaving in an abnormal manner on the screen test and subsequent tolerance tests were being classified as essentially normal when they visited their personal physician for a follow-up examination and diagnosis. It was found that in many instances the physician performed only a fasting urinalysis, and if positive results were not obtained the individual was dismissed as normal. Most authorities on diabetes have recognized the fact that in many cases a diabetic individual will fail to excrete sugar in a *fasting* urine specimen. It was felt that a considerable number of individuals were being classed as normal as a result of this practice. It was realized that in many cases the rural physician, and most of the present survey work is done in rural areas, is unable to perform a glucose tolerance test and a complete urinalysis on each individual, due primarily to a lack of laboratory facilities and equipment adequate for such testing. For this reason, in the most recent survey and with the approval of the medical society, a urinalysis examination was added to the testing procedure performed at the time of the confirmatory glucose tolerance test. It was felt that the added information supplied to the physician when a suspicious case is referred to him would greatly facilitate his diagnosis.

It should be emphasized that the diabetes detection program is presently carried out only as a detection service and not as a diagnostic campaign. The battery of tests performed by the laboratory merely indicates some abnormality of sugar metabolism, and it becomes the job of the personal physician to determine whether or not this abnormality may be caused by diabetes, hyperpituitarism, pregnancy, gallbladder disease, prolonged bed rest, repeated insulin administration in a non-diabetic individual, arteriosclerosis, chronic arthritis, apoplexy, hepatic cirrhosis, low carbohydrate diet, hyperthyroidism, acromegaly, ulcerative colitis, old age, overweight, or any of

the other causes of hyperglycemia.

It should be stressed and understood by the medical profession that as our case finding program develops we will need the support and cooperation of all the medical societies and each individual member of the medical profession. Experience has shown that diabetes detection can best be carried out through local groups each of which thoroughly understands the individual circumstances of its own particular community. The diabetes case finding program offers an opportunity to demonstrate once again the continuing leadership of the medical profession in fostering preventive medicine for the good health and well being of all.

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COUNTIES REPORTING FOR 1951

Bartow County Medical Society

President—William B. Quillian, Jr., Cartersville
Vice President—H. B. Bradford, Cartersville
Secretary-Treasurer—A. L. Horton, Cartersville
Censors—William B. Quillian, Jr., H. B. Bradford, and S. M. Howell, all of Cartersville

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Brooks County Medical Society

President—A. B. Jones, Jr., Quitman
Vice President—L. A. Smith, Quitman
Secretary-Treasurer—Walter G. Thwaite, Quitman
Delegate—L. A. Smith, Quitman
Alternate Delegate—Walter G. Thwaite, Quitman

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Bulloch-Candler-Evans Medical Society

President—Curtis G. Hames, Claxton
Vice President—Albert M. Deal, Statesboro
Secretary-Treasurer—Louie H. Griffin, Claxton
Delegate—John Mooney, Jr., Statesboro
Alternate Delegate—R. L. Kennedy, Metter
Censors—Ben A. Deal, Statesboro; W. E. Simmons, Metter, and J. H. Whiteside, Statesboro

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Burke County Medical Society

President—D. L. Butterfield, Waynesboro
Vice President—C. G. Green, Waynesboro
Secretary-Treasurer—Cleveland Thompson, Jr., Waynesboro
Delegate—Cleveland Thompson, Sr., Waynesboro
Alternate Delegate—J. M. Byne, Jr., Waynesboro

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Cherokee-Pickens Medical Society

President—Charles R. Andrews, Jr., Canton
Vice President—G. H. Perrow, Jasper
Secretary-Treasurer—A. M. Hendrix, Canton
Delegate—Ben K. Looper, Canton
Alternate Delegate—C. J. Roper, Jasper
Censors—George C. Brooke, Robert T. Jones, III, both of Canton, and C. J. Roper, Jasper

Clayton-Fayette Medical Society

President—J. R. Wallis, Lovejoy
Vice President—Y. R. Coleman, Jonesboro
Secretary-Treasurer—R. P. Campbell, Fayetteville
Delegate—T. J. Busey, Fayetteville

* * *

Coweta County Medical Society

President—C. C. Elliott, Sargent
Secretary-Treasurer—J. H. Arnold, Newnan
Delegate—G. W. Hammond, Newnan
Alternate Delegate—H. D. Meaders, Newnan

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Crisp County Medical Society

President—C. E. McArthur, Cordele
Secretary-Treasurer—O. T. Gower, Jr., Cordele
Delegate—P. L. Williams, Cordele
Alternate Delegate—C. E. McArthur, Cordele

* * *

Decatur-Seminole Medical Society

President—Henry A. Bridges, Donalsonville
Vice President—Carl B. Welch, Attapulgus
Secretary-Treasurer—M. A. Ehrlich, Bainbridge
Delegate—Harry B. Baxley, Donalsonville
Alternate Delegate—John P. Tucker, Bainbridge

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DeKalb County Medical Society

President—Richard H. Smoot, Decatur
Vice President—Robert B. Ansley, Decatur
Secretary-Treasurer—Chester W. Morse, Decatur
Delegate—J. Rufus Evans, Stone Mountain
Alternate Delegate—Floyd R. Sanders, Decatur
PR Chairman—H. Homer Allen, Decatur

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Fulton County Medical Society

President—Hal M. Davison, Atlanta
President-Elect—Jack C. Norris, Atlanta
Vice President—William A. Smith, Atlanta
Secretary-Treasurer—Tully T. Blalock, Atlanta
Delegates—Wm. G. Hamm, Hal M. Davison, William A. Smith, Tully T. Blalock, A. O. Linch, Jack C. Norris, John W. Turner, B. L. Shackleford, J. D. Martin, Jr., Edgar Boling, C. Purcell Roberts, and W. S. Dorrough, all of Atlanta

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Habersham County Medical Society

President—Joe J. Arrendale, Cornelia
Vice President—George T. Nicholson, Cornelia
Secretary-Treasurer—J. L. Walker, Clarksville
Delegate—George T. Nicholson, Cornelia
Alternate Delegate—D. H. Garrison, Clarksville
Censors—B. J. Roberts and T. H. Brabson, both of Cornelia
PR Chairman—George T. Nicholson, Cornelia

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Hall County Medical Society

President—Billy S. Hardman, Gainesville
Vice President—W. Ben McNalley, Helen
Secretary-Treasurer—C. W. Whitworth, Gainesville
Delegate—Billy S. Hardman, Gainesville
Alternate Delegate—B. A. McCrum, Gainesville
Censors—Derrell C. Sirmons, Dahlonga; W. Raleigh Garner and C. W. Whitworth, both of Gainesville

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Houston-Peach Medical Society

Secretary-Treasurer—A. G. Hendrick, Perry
Delegate—A. Smoak Marshall, Fort Valley
Alternate Delegate—A. G. Hendrick, Perry

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Jackson-Barrow Medical Society

President—W. Q. Randolph, Winder
Vice President—J. T. Stovall, Jefferson
Secretary-Treasurer—Lewis W. Moore, Winder
Delegate—Alex B. Russell, Winder

* * *

Jasper County Medical Society

President—F. S. Belcher, Monticello
Vice President—Albert Fisher, Jr., Monticello
Secretary-Treasurer—E. M. Lancaster, Shady Dale
Delegate—E. M. Lancaster, Shady Dale

Lamar County Medical Society

President—J. H. Jackson, Barnesville
 Vice President—John B. Crawford, Barnesville
 Secretary-Treasurer—S. B. T aylor, Barnesville
 Delegate—J. A. Corry, Barnesville
 Alternate Delegate—D. W. Pritchett, Barnesville

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Monroe County Medical Society

President—George H. Alexander, Forsyth
 Secretary-Treasurer—A. Walter Bramblett, Jr., Forsyth
 Delegate—George H. Alexander, Forsyth

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Morgan County Medical Society

President—J. H. Nicholson, Madison
 Vice President—C. H. Dickens, Madison
 Secretary-Treasurer—W. C. McGeary, Madison
 Delegate—J. H. Nicholson, Madison
 Alternate Delegate—Edward O. White, Madison

* * *

Polk County Medical Society

President—William H. Blanchard, Cedartown
 Vice President—W. H. Lucas, Cedartown
 Secretary-Treasurer—Cecil B. Elliott, Cedartown
 Delegate—W. H. Lucas, Cedartown
 Alternate Delegate—O. R. Styles, Cedartown
 Censors—Raymond J. Spanjer, Cedartown; J. E. Griffith, Cedartown, and William H. Blanchard, Cedartown

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Richmond County Medical Society

President—Thomas W. Goodwin, Augusta
 President-Elect—Stephen W. Brown, Augusta
 Vice President—J. Victor Roule, Augusta
 Secretary-Treasurer—J. K. Philpot, Augusta
 Delegates—David R. Thomas, John M. Martin and R. C. McGahee, all of Augusta
 Alternate Delegates—J. Victor Roule, John M. Miller and F. N. Harrison, all of Augusta
 PR Chairman—J. Robert Rinker, Augusta

* * *

Tift County Medical Society

President—Robert E. Jones, Tifton
 Vice President—Paul W. Lucas, Tifton
 Secretary-Treasurer—Tom L. Edmondson, Tifton
 Delegate—Carlton A. Fleming, Tifton
 Alternate Delegate—C. S. Pittman, Jr., Tifton

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Tri-County Medical Society

(Liberty-Long-McIntosh Counties)

Secretary-Treasurer—O. D. Middleton, Ludowici
 Delegate—I. G. Armistead, Townsend

* * *

Walton County Medical Society

President—Lynn M. Huie, Monroe
 Vice President—Homer Head, Monroe
 Secretary-Treasurer—Harry B. Nunnally, Monroe
 Delegate—Lynn M. Huie, Monroe
 Alternate Delegate—Harry B. Nunnally, Monroe
 PR Chairman—Lynn M. Huie, Monroe

* * *

Ware County Medical Society

President—W. C. Calhoun, Waycross
 Vice President—Henry T. Adkins, Waycross
 Secretary-Treasurer—Leo Smith, Waycross
 Delegate—W. L. Pomeroy, Waycross
 Alternate Delegate—Leo Smith, Waycross
 Censors—W. A. Hendry, Blackshear; W. M. Flanigan, and H. A. Seaman, both of Waycross

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Warren County Medical Society

President—H. B. Cason, Warrenton
 Secretary-Treasurer—A. W. Davis, Warrenton
 Delegate—H. B. Cason, Warrenton

* * *

Whitfield County Medical Society

President—E. A. Rosen, Dalton
 Vice President—Paul L. Bradley, Dalton
 Secretary-Treasurer—H. J. Ault, Dalton
 Delegate—Trammell Starr, Dalton
 Censors—J. E. Bradford, Spring Place; James R. Whit-

ley, and H. L. Erwin, both of Dalton
 PR Chairman—D. Lloyd Wood, Dalton

* * *

Wilkes County Medical Society

President—C. E. Wills, Jr., Washington
 Vice President—A. W. Simpson, Jr., Washington
 Secretary-Treasurer—M. C. Adair, Washington
 Delegate—A. Dan Duggan, Washington
 Alternate Delegate—C. E. Wills, Sr., Washington

NEWS ITEMS

The Appling County Medical Society held its monthly meeting at the First Baptist Church, Baxley, January 16. Program: "Pepic Ulcers", Dr. J. B. Brown, Baxley. The society met with the county and city officials and the hospital authority to work out plans for the opening of the Appling General Hospital, Baxley, at an early date.

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Dr. Walter L. Bloom, Atlanta physician, and assistant professor of biochemistry at Emory University School of Medicine, was reported to have achieved "encouraging results" in developing a solution called "dextran", a substitute for blood plasma in treatment of shock cases. Dr. Bloom has used the solution at Emory and Grady Hospitals "very successfully." He pointed out that "dextran," which he called "a product of fermentation of certain streptococcus-like bacteria on common table sugar, can be used only for shock, and does not match the protein-replacing and anti-infection qualities of plasma. The discovery is expected to be of great value in case of atom bomb attacks.

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Dr. Edward E. Brown, a native of LaGrange, announces his association with Dr. R. B. Gilbert, Gilbert Clinic, Greenville, for the practice of medicine.

* * *

Dr. Ellison Richard Cook, Savannah physician, was recently named Savannah's "Outstanding Man for the Year 1950" by a Junior Chamber of Commerce-appointed panel of judges at the Jaycees annual "Bosses' Night" and Founder's Day banquet held at the Hotel Savannah. In announcing the selection, the judges cited Dr. Cook's unselfish community work in establishing the heart clinic at the Community Health Center and as medical adviser to the Savannah Chapter of the American Red Cross. The establishment of the heart clinic was termed "a notable addition to the public welfare . . . from which the benefits will be of untold value to hundreds, even thousands of our people." In further support of their selection, the judges said ". . . what a happy circumstance it is that this young man, so skilled personally in his profession, looks with enthusiasm upon the higher opportunity that comes to a man in the service of his church and in the teachings of the Master. It is not only the mundane features of life that excite his interest but the spiritual experience that draws him to labor in the field of morality as well."

* * *

Dr. E. C. Demmond, Savannah physician, was recently elected president of the Hospital Service Association, Savannah. Dr. Michael J. Egan, outgoing president, presided at the meeting, and was given a rising vote of thanks from the members for the outstanding job he did during his term of office. Dr. St. J. R. deCaradeuc is a member of the executive committee. The committee has a representative from each of the local hospitals serving on it.

* * *

The Fulton County Medical Society held its semi-monthly dinner meeting at the Academy of Medicine, Atlanta, February 15. Scientific meeting—Dr. Ted Leigh, moderator. "Indications for Uretero-Intestinal Anastomosis and Rehabilitation," Dr. Chester A. Fort. "Clinical Use of ACTH—A Summary," Dr. Arthur J. Merrill. Discussion by Dr. Philip K. Bondy.

* * *

Dr. Charles E. Dowman, Atlanta, announces the removal of his offices from 1028 West Peachtree Street, N. W., to 1415 Peachtree Street, N. E., Atlanta. Practice limited to neurosurgery.

Dr. Wallace M. Gibson, Milledgeville, of the Milledgeville State Hospital staff has been named chairman of the Baldwin County unit of the American Cancer Society.

* * *

Dr. W. A. Hendry and his wife, Dr. Katherine M. Hendry, Blackshear physicians, recently attended the International Medical Assembly, a postgraduate school, sponsored by the Inter-State Postgraduate Association of North America, held in Chicago.

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Dr. Albert J. Kelley, Savannah physician, was recently elected president of the Chatham-Savannah Health Council. Other officers elected were: Dr. H. H. McGee, president-elect; Dr. Ann Hopkins, vice president. Board of Trustees: Dr. T. A. Peterson, Dr. A. F. Williams, Dr. F. Bland Tucker, Dr. William Weichselbaum, Jr., Dr. C. A. Peterson, Dr. Lawrence Lee, Dr. Laurence Dunn, Dr. Ruskin King and Dr. Ellison R. Cook.

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Dr. J. H. Kite, Atlanta orthopedic surgeon and staff member of the Scottish Rite Hospital, was recently guest speaker at the Jasper County Masonic meeting held at the Masonic Temple, Shady Dale.

* * *

Dr. W. D. Lundquist, formerly of Augusta, has returned to his former post as health commissioner of the East-Central Health Region, with headquarters in Statesboro. He will serve Bryan, Bulloch, Effingham and Evans Counties. The office of health commissioner has been vacant since Dr. Lundquist went to Augusta early in 1950.

* * *

Dr. William McCollum, Thomasville, announces the opening of his offices at 314 Broad Avenue, Thomasville, for the practice of medicine. Dr. McCollum graduated from the Medical College of Georgia and interned at University Hospital, Augusta, also served as resident physician. He was in the Medical Corps of the U. S. Army for two years.

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Macon Hospital Medical Staff for 1951 is named: Dr. J. C. Anderson, president; Dr. Ralph G. Newton, vice president; Dr. Thomas L. Ross, Jr., chief of staff; Dr. Milford B. Hatcher, chairman, executive committee; serving with Dr. Hatcher will be Dr. S. E. Patton, Dr. A. M. Phillips, Dr. W. C. Boswell, and Dr. J. I. Hall. Drs. J. B. Kay and T. E. Rogers were named as honorary staff members.

The 1951 staff members and associates along with the medical services follow:

Surgery: Dr. H. G. Weaver, Dr. Ralph Newton, Dr. C. N. Wasden, with Dr. Milford B. Hatcher, Dr. C. H. Richardson, Jr., Dr. Earl Lewis, Dr. E. C. McMillan, Dr. Charles L. Ridley, Jr., and Dr. J. P. Woodhall as associates.

Medicine: Dr. W. D. Hazlehurst, Dr. J. F. Hanson and Dr. S. E. Patton, with Dr. H. H. Tift, Dr. A. A. Cole, Dr. Holloway Bush, Dr. L. P. James and Dr. Rudolph Jones as associates.

Gynecology: Dr. Frank Houser, Dr. R. W. Edenfield and Dr. W. W. Baxley, with Dr. R. G. Ferrell, Dr. J. B. Stewart, Dr. Jule C. Neal and Dr. Raymond Suarez as associates.

Obstetrics: Dr. W. K. Jordan, Dr. E. A. Brannen and Dr. Evelyn Swilling, with Dr. Leon Goodman, Dr. T. E. Rogers, Jr., Dr. Sam D. Work and Dr. Roland Brown as associates.

Genito-Urinary: Dr. Wallace Bazemore, Dr. W. R. Golsan and Dr. R. W. McAllister, with Dr. Ed R. Stamps as associate.

Pediatrics: Dr. Edwin R. Watson, Dr. Charles Rumble and Dr. W. C. Boswell, with Dr. John Paul Jones, Dr. Charlotte Neuberger and Dr. W. W. Orr as associates.

Orthopedics: Dr. W. A. Newman and Dr. John I. Hall with Dr. Leon D. Porch as associate.

Eye, Nose, Throat: Dr. R. W. Richardson, Dr. William Barton and Dr. J. W. McFarlane.

Cancer: Dr. Thomas Harrold, director, with Dr. Milford B. Hatcher, associate director, with Dr. W. L. Barton, Dr. R. W. Edenfield, Dr. W. D. Hazlehurst, Dr.

R. W. McAllister, Dr. C. K. McLaughlin, Dr. Max Mass, Dr. R. M. Reiffer, Dr. C. H. Richardson, Jr., Dr. C. L. Ridley, Jr., Dr. J. B. Stewart, Dr. J. P. Woodhall, Dr. Jule C. Neal, Dr. W. E. Lewis and Dr. H. Olmick.

Endoscopy: Dr. William Barton.

Proctology: Dr. A. M. Phillips.

Ophthalmology: Dr. C. K. McLaughlin.

Pathology and X-ray: Dr. Max Mass.

Dental: Dr. F. R. Childs, Dr. P. O. Holliday and Dr. H. Cohen.

Dermatology: Dr. R. M. Reiffer and Dr. Carl Anderson.

Syphilology: Dr. W. W. Meriwether.

Psychiatry: Dr. J. R. S. Mays and Dr. George Billingshurst.

Cardiology: Dr. Thomas L. Ross, Jr., with Dr. B. W. Forester as associate.

Anesthesiology: Dr. Charles Benton.

The consultant staff as released by Dr. Ridley is composed of the following:

Surgery: Dr. C. H. Richardson, Sr., and Dr. O. F. Keen.

Medicine: Dr. H. C. Atkinson, Dr. A. E. Siegel, Dr. J. B. Kay, Dr. W. A. Williams, Dr. Frank Vinson and Dr. J. D. Applewhite.

Obstetrics: Dr. O. R. Thompson and Dr. J. L. King.

Gynecology: Dr. J. C. Anderson.

Genito-Urinary: Dr. Ernest Corn.

Pediatrics: Dr. R. C. Goolsby and Dr. Hall Farmer.

Dental: Dr. W. B. Childs, Dr. Palmer Saunders, Dr. Frampton Farmer and Dr. C. A. Yarbrough.

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Dr. Howard J. Morrison, Savannah physician, presented a paper entitled "Breast Feeding" at the clinical session of the American Medical Association held in Washington, D. C., some thirteen months ago, won such acclaim that extensions of the original paper have been scheduled to appear in three publications of national circulation. His paper was first reprinted in the December, 1950 issue of the Armed Forces Medical Journal. Child-Family Digest requested permission to republish it in a slightly revised form. *Today's Health*, formerly known as *Hygeia*, expressed an interest in the topic and a nonprofessional version of the original paper has been prepared for it.

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The Muscogee County Medical Society held its January meeting at the Country Club, Columbus. Scientific program: "Individualized Anesthesias," Dr. John Stage, Jacksonville, Fla., anesthesiologist at Riverside, Duval County and Brewster Hospitals, Jacksonville.

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Dr. Charles L. Prince, Savannah, was recently elected a member of the Urologic Forum for Clinical Investigation at its session held at the Greenbrier Hotel, White Sulphur, W. Va. This exclusive organization is composed of young urologists of the nation and its membership is limited to twenty. Dr. Prince has practiced urology in Savannah for the past four years, coming from Baltimore, Md., where he was connected with the Johns Hopkins Hospital. He is associated with Dr. Peter L. Scardino in the practice of urology.

* * *

The Savannah Tumor Clinic, Savannah, has been approved by the American College of Surgeons as an institution conducting cancer clinics. Savannah's clinic was one of the 609 approved by the medical group from cancer clinics throughout the United States. The approvals are based on personal surveys by trained representatives of the college.

* * *

The Sixth District Medical Society held its semi-annual meeting at Regional Health Building, Macon, December 7. Dr. Leon Goodman, Dr. Herbert Olmick and Dr. T. P. Woodhall, all of Macon, read scientific papers. Officers elected were: Dr. Leon D. Porch, Macon, president; Dr. R. L. Taylor, Davisboro, vice president, and Dr. C. H. Richardson, Jr., Macon, secretary-treasurer.

The Woman's Auxiliary to the Sixth District Medical

Society elected the following officers: Mrs. Edwin Allen, Milledgeville, president; Mrs. William Jordan, Macon, president-elect; Mrs. Joseph E. Lever, Sandersville, secretary, and Mrs. James A. Wood, Macon, parliamentarian. A joint dinner meeting followed by a dance at the Idle Hour Country Club, climaxed the meetings.

* * *

Dr. John Edwin Taylor, Jr., Decatur, announces the opening of his offices at 356 West Ponce de Leon Avenue, Decatur. Practice limited to pediatrics. Dr. Taylor is a graduate of Emory University School of Medicine, Atlanta, in 1945. He was in the medical corps of the U. S. Navy for three years, and has served on the staffs of Crawford W. Long Memorial and Henrietta Eggleston Hospitals, Atlanta.

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The Veterans Administration Hospital (Lenwood), Augusta, recently had as guest speaker and to conduct a clinical pathologic conference Dr. Hans Popper, Chicago, Ill., chief of pathology, Cook County Hospital, and associate professor of pathology at Northwestern University Medical School. Dr. Popper coming to the Hospital is part of its medical training program. The subject of his paper was "Various Forms of Hepatitis." Dr. Leo R. Tighe, manager of the VA Hospital.

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Dr. James C. Thoroughman, formerly of Soochow, China, and Atlanta, is chief surgeon of the Veterans Administration Hospital, Augusta. Dr. Thoroughman recently passed the surgical boards and is certified by the American Board of Surgery.

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The Ware County Medical Society held its monthly dinner meeting at the Okefenokee Golf Club, Waycross, January 4. Dr. W. L. Pomeroy and Dr. Leo Smith were hosts. Dr. W. C. Calhoun, president, presided. Mr. Richard J. Eales, Atlanta, Executive Secretary in Charge of Public Relations of the Medical Association of Georgia was guest speaker.

* * *

Dr. T. F. Sellers, Atlanta, director of the Georgia Department of Public Health, was honored recently at the 30th annual meeting of the State and Provincial Laboratory Director's Conference at St. Louis, Mo. Widely known for his work in rabies control, Dr. Sellers received an "Oscar" for founding the organization in 1921. At that time he was director of the Georgia Department of Public Health Laboratory. He founded the group "to discuss problems of state laboratories."

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Dr. T. F. Sellers, Atlanta, director of the Georgia Department of Public Health, announces that Dr. Ralph C. Williams, a former Assistant Surgeon General of the U. S. Public Health Service, has joined the staff of the State Health Department as head of the Hospital Services Division. Dr. Williams, a native of Alabama, recently retired after more than 33 years with the Public Health Service. He is a graduate of the Medical College of Alabama, Birmingham. Dr. Sellers explained the Hospital Services Division administers the Hill-Burton program of hospital and health center construction in Georgia.

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Dr. C. A. Wilson, Jr., Brunswick, announces the removal of his offices to a new building at 801 Mansfield, Brunswick, for the practice of medicine.

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Dr. Jack J. Worth, Atlanta, announces the removal of his office to 1413 Miller Avenue, N. E., Atlanta, for the practice of medicine.

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Dr. Walter D. Martin, a native of Shellman, announces the opening of his offices on South Lee Street, Dawson, for the practice of medicine. His offices were formerly used by Dr. Steve P. Kenyon.

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Dr. Lee Howard, Jr., pathologist of Savannah, and Medical Director of the American Red Cross Regional Blood Bank, Savannah, was a guest lecturer on the

postgraduate lecture series at the Veterans Administration Hospital, Dublin, on February 15. The subject of his address was "Blood Banks and Blood Transfusions". The members of the Laurens County Medical Society were guests on this occasion.

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Dr. O. F. Whitman, Albany, Medical Director of the Southwestern Region of the Georgia Department of Public Health, attended the Sixth National Conference on Rural Health held at the Hotel Peabody, Memphis, Tenn., February 23 and 24, representing the Georgia Department of Public Health and the Medical Association of Georgia.

THE SOUTHEASTERN SURGICAL CONGRESS GRADUATE ASSEMBLY

Nineteenth Annual Meeting, April 11-14, 1951
Convening at Hollywood Beach Hotel, Hollywood, Fla.
Write Hotel Manager for reservations.

Guest speakers: Dr. Ray M. Bobbitt, Huntington, W. Va., Clinical Aspects of the Ectopic Ureter; Dr. Otto C. Brantigan, Baltimore, Md., Thoracoplasty in the Treatment of Pulmonary Tuberculosis; Dr. William S. Brockington, Greenwood, S. C., Xeroderma Pigmentosum; Dr. Robert J. Coffey, Washington, D. C., Gallstone Ileus: A Review of Fifteen Cases; Dr. H. Earle Conwell, Birmingham, Ala., The Treatment of Certain Complicated Pelvic Fractures; Dr. David B. Corcoran, Suffolk, Va., Continuous Lumbar Sympathetic Block; Dr. T. C. Davison, Atlanta, Ga., The Evaluation of Protein Bound Iodine Determination in Thyroid Disease; Dr. L. C. Feemster, Tupelo, Miss., Prostatectomy by the General Surgeon: Report of One Hundred Cases of Retro-pubic Prostatectomy; Dr. Cless Y. Fordyce, Baltimore, Md., Problems in Anesthesia of Special Interest to the Surgeon; Dr. Elmer Lee Henderson, Louisville, Ky., President, American Medical Association "1951"—Medicine's First Year of Grace; Dr. C. C. Howard, Glasgow, Kv., President, The Southeastern Surgical Congress, Accidents and a Proposed Program for Prevention; Dr. Hugh C. Ilgenfritz, Shreveport, La., Vertebral Osteochondroma; Dr. H. Reichard Kahle, New Orleans, La., Omphalocele; Dr. Linwood D. Keyser, Roanoke, Va., Urinary Calculi—Present Concepts of Etiology, Treatment and Prevention; Dr. Oswald S. Lowsley, New York City, Modern Methods of Diagnosis and Treatment in Urology; Dr. Herman Mahaffey, Louisville, Kv., Fibrosarcoma of Ileum with Report of Two Cases; Dr. John Martin, Chicago, Ill., The Diagnosis and Surgical Treatment of Intracranial Aneurysms; Dr. Michael L. Mason, Chicago, Ill., Irradiation Dermatitis of the Hands; Dr. Marshall L. Michel, New Orleans, La., Intestinal Obstruction in Infants and Children; Dr. A. T. Miller, Jr., Durham, N. C., Recent Studies on Obesity; Dr. Joe M. Parker, Oklahoma City, Okla., Prevention of Lymphedema of the Upper Extremity After Radical Mastectomy; Dr. Claud W. Perry, Anderson, S. C., Treatment of Fractures with Intra-Medullary Nail; Dr. Charles L. Prince, Savannah, Ga., The Management of Staghorn Renal Calculi; Dr. Leslie V. Rush, Meridian, Miss., Important Factors in the Medullary Fixation of Fractures; Dr. W. Hampton St. Clair, Bluefield, W. Va., Thyroidectomy; Dr. R. L. Sanders, Memphis, Tenn., Duodenal Ulcer and Its Complications; Dr. Paul W. Shannon, Birmingham, Ala., The Low Back Problem; Dr. N. S. Shofner, Nashville, Tenn., Malignant Tumors of the Thyroid Gland; Dr. Howard E. Snyder, Winfield, Kans., Serum Cholinesterase Levels in Surgical Patients; Dr. Clyde C. Sparks, Ashland, Ky., Common Benign Breast Lesions; Dr. Paul B. Steele, Pittsburgh, Pa., Evaluation of the Metallic S. M. O. Head; Dr. Ralph M. Stuck, Denver, Colo., Subdural Hematoma in Infants; Dr. Homer S. Swanson, Emory University, Ga., Congenital Arteriovenous Anomalies of the Cerebral Cortex. Their Surgical Treatment; Dr. Gershom J. Thompson, Rochester, Minn., Female Urologic Disorders Which Cause Abdominal Pain; Dr. James W. Watts, Washington, D. C., Angiography in Neurosurgery; Dr. Ashbel C. Williams, Jacksonville, Fla., Skin Grafts in the Treatment of Extensive Pilonidal Sinus and Ischio-rectal Abscess; Dr. Frank M. Woods, Miami, Fla., Abdominal

Tumors: A Urologic Perspective. For further information write Dr. B. T. Beasley, secretary, 701 Hurt Building, Atlanta 3, Ga.

DR. W. BARRY WOOD, JR., TO GIVE ANNUAL LECTURESHIP

Dr. W. Barry Wood, Jr., St. Louis, Mo., will give the Annual Atlanta Clinical Society Lecture on the evening of Tuesday, March 27 at 8:00 P. M. The title of his presentation will be, "Studies on the Cellular Physiology of Acute Infections."

Dr. Wood is eminently qualified to talk on his chosen subject. He has carried out considerable research and put forth numerous publications on the subject of infectious diseases and chemotherapy. He is a member of the Society of American Bacteriologists, the Experimental Therapeutics Study Section, National Institute of Health, U. S. Public Health Service, National Research Council—being a member of the Subcommittee on Infectious Diseases and Chemotherapy of the Committee on Medicine. He is also a member of the Commission on Streptococcal Diseases for the Armed Forces Epidemiological Board, and a member of the Central Board, Armed Forces Epidemiological Board.

He is a member of numerous national medical societies, inclusive of the Society of Clinical Investigation, Society for Experimental Biology and Medicine, Central Society for Clinical Research (and is Vice-President of this organization). He is a member of the American Medical Association, a Fellow of the American College of Physicians, of the Association of American Physicians. He is also a member of the Sigma Xi, Alpha Omega Alpha and Phi Beta Kappa Honorary Societies.

Dr. Wood has long been before the public eye. He began as Captain of the Harvard University football team and was an All-American quarterback. He excelled in several other sports, and in particular was a national ranking tennis player during his college and medical school days. Along with his athletic career he combined a remarkable scholastic aptitude and graduated from Harvard College, Summa Cum Laude. Following his graduation from Harvard in 1932, he entered Johns Hopkins Medical School. While there he continued his investigative career which had started during senior year in Harvard College, when he carried out studies on the response of the white blood cell count to exercise on members of the college football squad. Several publications on investigative work were presented during his medical school years, and following graduation from the Hopkins in 1936, he undertook internship at the Johns Hopkins Hospital, in Medicine, from 1936 to 1937.

He continued his training there, as Assistant Resident in Medicine, until 1939 when he was awarded a National Research Council Fellowship, in Bacteriology, at Harvard Medical School, which position he maintained until 1940. He returned to Johns Hopkins Medical School as Associate in the Department of Medicine for the years 1940 to 1942. It was in 1942 that he was appointed Professor of Medicine and Chairman of the Department of Medicine at Washington University School of Medicine, St. Louis, Missouri. He has continued the promise of his earlier career and has intensified the interest in the investigative program in the Department of Medicine at St. Louis. In addition to his professorial work he also carries on considerable work in an advisory capacity for the National Institute of Health and the National Research Council. Dr. Wood is a national figure in medicine and is well known for the excellence of his lectures.

The Clinical Society feels highly honored in having him for their annual lecturer.

SESSION OF THE GEORGIA CHAPTER OF THE A. C. C. P.

An interesting Scientific Program was held at the Fulton County Academy of Medicine sponsored by the Georgia Chapter of the American College of Chest Physicians on March 27, 1951. Papers were presented by Dr. Louis Mark of Columbus, Ohio, Dr. Burgess L.

Gordon of Philadelphia, Pa., and Dr. Louis Friedman of Birmingham, Alabama. Preceding the Scientific Session a dinner and business meeting was held at the Biltmore Hotel. Mr. Murray Kornfeld, Executive Secretary, of the American College of Chest Physicians met with the members and their guests for this meeting. The following officers for the Georgia Chapter were elected:

President—Dr. A. Worth Hobby

Vice President—Dr. J. C. Burch

Secretary and Treasurer—Dr. Joe S. Cruise

Chairman of Program Committee — Dr. Wm. A. Hopkins.

Fellows of the American College of Chest Physicians include surgeons and medical men as well as cardiologists who treat diseases of the chest. The organizational meeting of the Georgia Chapter of this group was held in Savannah, Georgia, in 1944. Since that time annual meetings have usually been held in conjunction with the meeting of the Medical Association of Georgia.

JOE S. CRUISE, M.D.

Secy.-Treas., Georgia Chapter,

American College of Chest Physicians

OBITUARY

Dr. Charles Glenville Giddings, Sr., aged 89, esteemed Atlanta general practitioner and diagnostician for more than half a century, died in an Atlanta hospital February 24, 1951. Dr. Giddings was born in Leesburg, Loudoun County, Virginia. He graduated from the University of Virginia Department of Medicine, Charlottesville, Va., in 1884. He interned and was house physician at Mt. Sinai Hospital. He also did work at Bellevue Hospital, New York City. Coming to Atlanta as a young man, Dr. Giddings married Miss Maude Crichton, of Atlanta, who died several years ago. He was a member of the All Saints Episcopal Church and the Sons of the American Revolution. He was an honorary member of the Fulton County Medical Society, the Medical Association of Georgia, and the American Medical Association. At the Savannah meeting of the Medical Association of Georgia in 1949, Dr. Giddings was among the Georgia physicians to receive a Certificate of Distinction and gold lapel button for his 50 years in the practice of medicine. In January the Fulton County Medical Society bestowed its highest honor—an honorary presidency—upon Dr. Giddings. Surviving are a son, Dr. Glenville Giddings, Jr.; a daughter, Mrs. W. C. Caye; two sisters, Mrs. Edward Martin, Washington, D. C., and Mrs. Ralph Graves, Leesburg, Va.; five grandchildren and two great-grandchildren. Funeral services were held at Spring Hill with Dr. Matthew Warren officiating. Burial was in West View Cemetery, Atlanta.

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Dr. Walter Roundtree, aged 79, prominent retired physician of Summit, died at his residence, January 5, 1951. Dr. Roundtree was born in Emanuel County, Georgia, son of the late William Perry Roundtree and Laura Coleman Roundtree. He graduated from the University of Georgia School of Medicine, Augusta, in 1899. He graduated from the University of Georgia School of Medicine, Augusta, in 1899. Last year, Dr. Roundtree was awarded by the Medical Association of Georgia Certificate of Distinction for his 50 years in the practice of medicine. Survivors include his wife, Mrs. Belle G. Roundtree; three sons, John Ellis Roundtree, Summit, George P. Roundtree, Atlanta, and W. H. Roundtree, Swainsboro; one daughter, Mrs. Virgil Clark, Summit, and three sisters. Funeral services were held at the Missionary Baptist Church with the Rev. Rufus Hodges, assisted by Elder P. H. Bird, officiating. Burial was in City Cemetery, Summit.

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Dr. Claude A. Smith, aged 78, Stockbridge physician, died February 8, 1951. Dr. Smith was born in Atlanta, the son of the late Dr. Francis Smith, pioneer Atlanta dentist, and Mrs. Smith. He graduated from the Southern Medical College, Atlanta, in 1898. He was former bacteriologist for the Georgia Department of Public Health, Atlanta. He received many honors for his re-

search in hookworm disease. At the annual session of the Medical Association of Georgia held in Macon, 1950, he was awarded the Ware County Medical Society Hookworm Cup which was presented to the Medical Association of Georgia to be awarded annually to that member who has done the most outstanding work in the eradication of hookworm disease. He received at the same meeting the Certificate of Distinction for his 50 years of distinguished service in the medical profession. Surviving are his wife, three sisters, Mrs. Cola Spears, Atlanta; Mrs. J. T. McGee, Macon; Mrs. Frank Nall, Demorest; two brothers, Sam Smith, Bolling Green, S. C., and Weaver Smith, Stockbridge. Graveside funeral services were held in Oakland Cemetery with the Rev. John Maxwell officiating. Burial was in Oakland Cemetery, Atlanta.

* * *

Dr. Marvin F. Smith, aged 71, general practitioner of internal medicine in Atlanta for 32 years, died at his residence, 1021 North Avenue, N. E., Atlanta, January 30, 1951. Born in Jackson County, Georgia, Dr. Smith graduated from the Atlanta Medical College, now Emory University School of Medicine, Atlanta, in 1913. He did postgraduate work at the New York Polyclinic Medical School and Hospital, New York City. He was a member of the Fulton County Medical Society, the Medical Association of Georgia and the American Medical Association. He was a member of the Westminster Presbyterian Church. Surviving are his wife, Mrs. Marvin F. Smith, Atlanta; a brother Redford Smith, Brownfield, Texas, and several nieces and nephews. Funeral services were held at Spring Hill with Dr. John R. Richardson, pastor of Westminster Presbyterian Church, officiating. Burial was in West View Cemetery, Atlanta.

* * *

Dr. Homer R. Maulding, aged 42, Atlanta physician, died at his home, 936 Coventry Road, Decatur, following a long illness, March 3, 1951. Dr. Maulding, a native of Dallas, came to Atlanta in 1935 after graduating from the University of Georgia School of Medicine, Augusta. He interned at Georgia Baptist Hospital, Atlanta. He specialized in obstetrics and gynecology. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the Southeastern Surgical Congress, and the American Medical Association. He was also a member of the Pythagoras Masonic Lodge No. 41, F. & A. M., and the Alpha Omega Fraternity. He is survived by his wife, the former Miss Thelma Ivey of Augusta; his parents, Mr. and Mrs. T. J. Maulding, Dallas; three brothers and several nieces and nephews. Funeral services were held at Spring Hill with the Rev. Foster Young officiating. Burial was in West View Cemetery, Atlanta.

* * *

Dr. Thomas Green Ritch, aged 60, one of the best known and most beloved physicians of Jesup and Wayne County, died at his home in Jesup, February 12, 1951. Dr. Ritch was the son of the late Tilla Idell Crosby and James Colquitt Ritch, who was a Wayne County farmer and naval stores operator. He graduated from the Atlanta College of Physicians and Surgeons, Atlanta, in 1911, and practiced medicine a short time in St. Mary's, then Screven and Odum. After returning from World War I in 1919, he entered the practice of medicine in Jesup as a physician, surgeon and part owner of Ritch-Leaphart Hospital. He was a member of the Jesup Methodist Church and chairman of the Board of Trustees, President of the Jesup and Wayne County Chamber of Commerce, Vice President of the Jesup Baseball Club. He was a charter member of the Kiwanis Club and American Legion, a Mason, member of the Wayne County Medical Society, Medical Association of Georgia, Southeastern Surgical Congress and the American Medical Association. Dr. Ritch was voted the most outstanding citizen of his community a few years ago as a result of his services as a Jesup City Councilor. He served for

several years as chairman of the City Board of Education and was formerly a member of the County Board of Health. He is survived by his wife, the former Miss Nora Strickland, of Jesup; two daughters, Mrs. J. H. Sullivan and Dr. Una Ritch Yeomans, both of Jesup; one son, T. G. Ritch, Jr., Jesup; two sisters, one brother, and two granddaughters. Funeral services were held at the Jesup Methodist Church with the Rev. C. R. McKibben, pastor, officiating, assisted by the Rev. Floyd T. Jenkins, pastor of Jesup Baptist Church. Burial was in Jesup Cemetery.

CHEMISTRY AND MEDICINE

The romance of chemistry and medicine is truly a fascinating story, for it is their alliance that has markedly produced many of the advances in the care of the sick, the Educational Committee of the Illinois State Medical Society observes in a HEALTH TALK. Experiments in the field of chemistry are continually providing new and powerful drugs to fight disease, while advances in knowledge of the chemistry of the body have provided a better understanding of many disease processes as well as with tools useful for diagnosis and treatment.

A hundred years ago crude plant or vegetable preparations, hardly worthy of being called drugs, were in use. These have slipped rapidly into oblivion as the organic chemist began to supply the medical researchers with pure chemical compounds.

Chemotherapy, which means treatment with chemicals, came into being with the work of Ehrlich who kept trying to find a cure for syphilis among hundreds of organic arsenical compounds. Out of the chemical laboratory have evolved the harbiturate drugs which are useful as sedatives, a variety of exceedingly valuable local anesthetics; vitamins and hormones, and extraction of insulin from the pancreas of animals by chemical methods provided the life-saving drug for the diabetic.

Until 1930 when Domagk of Germany discovered Prontosil, there was no drug of real value in treating many infectious diseases. While there were some agents available that killed the organisms in the test tube, these could not be tolerated by the patient. Prontosil was the greatest discovery in chemotherapy since the pioneer work of Ehrlich in syphilis. Further chemical research proved that Prontosil broke down to sulfanilamide in the body and it was this compound, rather than Prontosil itself, that was the active antibacterial agent. From this discovery stemmed the family of so-called "sulpha" drugs used in the severe streptococcal and staphylococcal infections.

But science did not stop here, for within the past ten years penicillin and other life-saving antibiotic drugs such as streptomycin, aureomycin and chloromycetin have supplanted the sulphonamides to a considerable extent. With them, a new group of infectious diseases, such as typhoid fever and Rocky Mountain Spotted Fever, were placed under control.

During World War II, new chemical agents were found to fight malaria, and in very recent years the development of antihistaminic drugs marked new advances in certain conditions. The drugs cortisone and ACTH, or adrenocorticotrophic hormone, may also be classed among the greater medical discoveries of all times.

The physician relies upon a large number of chemical tests on blood and other body fluids or tissues to aid him in establishing a correct diagnosis and to follow the progress of treatment in his patients.

The progress of medicine has made the United States the healthiest country in the world. Early diagnosis of disease, prevention of disease and when disease developed, its proper management—all these are the result of medical advances. A large share of credit goes to the field of chemistry for the development of the chemotherapeutic agents, and to medicine for the wisdom needed for their application.

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA



MRS. LEHMAN W. WILLIAMS
Savannah
President 1950-1951

INVITATIONS

Augusta, Ga., Mar. 1, 1951

To the Members of the Woman's Auxiliary,

Medical Association of Georgia:

The Woman's Auxiliary to the Richmond County Medical Society takes great pleasure in extending a most cordial invitation to the Auxiliary members throughout Georgia to meet with us in Augusta at the annual convention April 17-20.

We also extend an invitation to doctors' wives who are not Auxiliary members to take part in all of our activities during the convention.

An instructive and entertaining program has been planned. Your presence is needed to help make this convention a success and we are looking forward to seeing you in Augusta in April.

Sincerely,

MRS. J. PHINIZY HITCHCOCK, President,
Woman's Auxiliary to the Richmond County
Medical Society.

PRESIDENT'S INVITATION

Savannah, Ga., Mar. 1, 1951

To all members of the Woman's Auxiliary to the Medical Association of Georgia, and also to the doctors' wives who are not members of the Auxiliary:

I extend my sincere greetings and a very cordial invitation to attend our Auxiliary meetings during our Twenty-sixth Annual Convention in Augusta, April 17-20.

A large attendance of Auxiliary members and guests, will be an inspiration to your State President, and to our hostesses, The Auxiliary to the Richmond County Medical Society. Plans are being made to make your visit a pleasant one, as well as interesting.

I will be looking forward to seeing each of you.

Let us not forget our pledge of Loyalty and Devotion to our Auxiliary.

Sincerely yours,

MRS. LEHMAN W. WILLIAMS, President
Woman's Auxiliary to the Medical
Association of Georgia.

PROGRAM

TWENTY-SIXTH ANNUAL CONVENTION
of the
WOMAN'S AUXILIARY
to the
MEDICAL ASSOCIATION OF GEORGIA
Partridge Inn
AUGUSTA

April 17-18-19-20, 1951

OFFICERS AND COMMITTEES

Executive Board

President—Mrs. Lehman W. Williams, Savannah.
President-Elect—Mrs. J. R. S. Mays, Macon.
First Vice-President—Mrs. Ralph Fowler, Marietta.
Second Vice-President—Mrs. John W. Turner, Atlanta.
Third Vice-President—Mrs. Paul T. Russell, Albany.
Recording Secretary—Mrs. Leo Smith, Waycross.
Corresponding Secretary—Mrs. C. R. A. Redmond, Savannah.
Treasurer—Mrs. Lucius N. Todd, Augusta.
Historian—Mrs. Robert Crichton, Milledgeville.
Parliamentarian—Mrs. W. Bruce Schaefer, Toccoa.

Advisory Committee

Dr. Murdock Euen, Chairman, Atlanta.
Dr. Lehman W. Williams, Savannah
Dr. Eustace A. Allen, Atlanta.
Dr. W. Bruce Schaefer, Toccoa.
Dr. Ralph H. Chaney, Augusta.
Dr. W. L. Bazemore, Macon.
Dr. J. Harry Rogers, Atlanta.
Dr. W. G. Elliott, Cuthbert.
Dr. J. R. S. Mays, Macon.

Chairmen of Standing Committees

1950-1951

Achievement Award—Mrs. William H. Benson, Marietta.
Archives—Mrs. C. W. Roberts, Atlanta.
Budget—Mrs. Ralph H. Chaney, Augusta.
Bulletin—Mrs. Milford B. Hatcher, Macon.
Doctors' Day—Mrs. Virgil Williams, Griffin.
Editorial—Mrs. Ben Hill Clifton, Atlanta.
Exhibit and Scrapbook Awards—Mrs. Dan Jardine, Douglas.
Legislation—Mrs. Harold Smith, Savannah.
Public Relations—Mrs. J. Harry Rogers, Atlanta.
Research in Romance of Medicine—Mrs. T. J. Ferrell, Waycross.
Revisions—Mrs. Lee Howard, Savannah.
Student Loan Fund—Mrs. Shelley C. Davis, Atlanta.
Mrs. James N. Brawner Trophy—Mrs. J. Harry Rogers, Atlanta.
Special Committee Camellia Garden—Mrs. R. W. Bradford, Milledgeville.

District Managers

First District—Mrs. T. A. Peterson, Savannah.
Second District—Mrs. R. K. Winston, Tifton.
Third District—Mrs. A. R. Sims, Richland.
Fourth District—Mrs. Virgil Williams, Griffin.
Fifth District—Mrs. Murdock Euen, Atlanta.

Sixth District—Mrs. J. R. S. Mays, Macon.
 Seventh District—Mrs. J. H. Mull, Rome.
 Eighth District—Mrs. J. L. Campbell, Jr., Valdosta.
 Ninth District—Mrs. C. J. Roper, Jasper.

PRESIDENTS OF COUNTY AUXILIARIES

Baldwin—Mrs. R. W. Bradford, Milledgeville.
 Barrow-Jackson—Mrs. Paul Scoggins, Commerce.
 Bibb—Mrs. William K. Jordan, Macon.
 Bulloch-Candler-Evans—Mrs. J. L. Nevill, Metter.
 Burke-Jenkins-Screven—Mrs. Cleveland Thompson, Waynesboro.
 Chatham—Mrs. S. F. Rosen, Savannah.
 Cherokee-Pickens—Mrs. Arthur Hendrix, Canton.
 Cobb—Mrs. Earl Benson, Marietta.
 Coffee—Mrs. Horace Joiner, Douglas.
 Coweta—Mrs. J. B. Peniston, Newnan.
 Colquitt—Mrs. R. E. Fokes, Jr., Moultrie.
 Crisp—Mrs. Charles McArthur, Cordele.
 Carroll-Douglas-Haralson—Mrs. C. V. Van Sant, Jr., Tallapoosa.
 Dougherty—Mrs. Mack Sutton, Albany.
 DeKalb—Mrs. W. A. Mendenhall, Chamblee.
 Dodge-Pulaski-Bleckley—Mrs. James L. Thomson, Eastman.
 Floyd—Mrs. Inman Smith, Rome.
 Fulton—Mrs. F. Kells Boland, Jr., Atlanta.
 Gordon—Mrs. J. E. Billings, Calhoun.
 Glynn—Mrs. Leon E. Brawner, St. Simons.
 Gwinnett—Mrs. R. E. Smith, Buford.
 Habersham—Mrs. J. L. Walker, Clarksville.
 Muscogee—Mrs. W. F. Jenkins, Columbus.
 Peach-Honston—Mrs. J. L. Gallemore, Perry.
 Randolph-Terrell—Mrs. T. F. Harper, Coleman.
 Richmond—Mrs. J. P. Hitchcock, Augusta.
 South Georgia—Mrs. I. Malcolm Gibson, Valdosta.
 Sumter—Mrs. William McMath, Americus.
 Stephens—Mrs. Arthur Singer, Toccoa.
 Tift—Mrs. R. K. Winston, Tifton.
 Troup—Mrs. E. W. Molyneaux, Hogansville.
 Upson—Mrs. R. E. Dallas, Thomaston.
 Ware—Mrs. Arthur Knight, Jr., Waycross.
 Washington—Mrs. Joseph Lever, Sandersville.
 Whitfield—Mrs. Eli Rosen, Dalton.

PAST PRESIDENTS AND CONVENTIONS

Honorary Presidents For Life

Mrs. James N. Brawner, 2800 Peachtree Road, N. E., Atlanta. (Named at 1939 Convention).
 Mrs. Eustace A. Allen, 18 Collier Road, N. W., Atlanta. (Named at 1949 Convention).
 1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta, Temporary Chairman.
 1925—Atlanta—Mrs. James N. Brawner, Atlanta.
 1926—Albany—Mrs. William H. Myers, Savannah.
 1927—Athens—Mrs. C. W. Roberts, Atlanta.
 1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S. C.).
 1929—Macon—Mrs. Charles C. Hinton, Macon.
 1930—Augusta—Mrs. Marion T. Benson, Atlanta.
 1931—Macon—Mrs. Charles C. Harrold, Macon.
 1932—Savannah—Mrs. Ralston Lattimore, Savannah.
 1933—Macon—Mrs. S. T. R. Revell, Louisville.
 1934—Augusta—*Mrs. J. Bonar White, Atlanta.
 1935—Atlanta—Mrs. J. E. Penland, Waycross.
 1936—Savannah—Mrs. Ernest R. Harris, Winder.
 1937—Macon—Mrs. William R. Dancy, Savannah.
 1938—Augusta—Mrs. Ralph Chaney, Augusta.
 1939—Atlanta—Mrs. Warren A. Coleman, Eastman.
 1940—Savannah—Mrs. Eustace A. Allen, Atlanta.
 1941—Macon—Mrs. H. G. Banister, Ila.
 1942—Augusta—Mrs. Lee Howard, Savannah.
 1943—Atlanta—Mrs. J. Lon King, Macon.
 1944—Savannah—Mrs. Olin S. Cofer, Atlanta.

* Deceased.

1946—Macon—Mrs. W. T. Randolph, Winder.
 1947—Augusta—Mrs. Bruce Schaefer, Toccoa.
 1948—Atlanta—Mrs. W. G. Elliott, Cuthbert.
 1949—Savannah—Mrs. S. A. Anderson, Atlanta.
 1950—Macon—Mrs. J. Harry Rogers, Atlanta.

WOMAN'S AUXILIARY TO THE RICHMOND COUNTY MEDICAL SOCIETY COMMITTEES

Credentials and Registration

Mrs. Malcolm Bazemore, Chairman	Mrs. J. E. Hummel Mrs. Lucius N. Todd
Mrs. F. N. Harrison	Mrs. Perry P. Volpitto
Mrs. Edgar Pund	Mrs. W. S. Boyd
Mrs. W. B. Walsh	

Decorations

Mrs. Charles Hock, General Chairman

Banquet

Mrs. Henry Perkins, Chairman	Mrs. W. W. Battey Mrs. Thomas Goodwin
Mrs. Robert Rinker, Co-Chairman	Mrs. J. L. Chandler Mrs. C. Monroe Templeton
Mrs. Byron C. Beard	Mrs. Richard Torpin
Mrs. Jack Sherman	Mrs. G. Lombard Kelly

Luncheon

Mrs. Jack Waters, Chairman	Mrs. James S. New Mrs. Victor Roule
Mrs. David Davis, Co-Chairman	Mrs. John Bowen Mrs. Jack Levy
Mrs. W. A. Wilkes	Mrs. Leonard Massengale
Mrs. Harry Harper	Mrs. W. G. Watson

Tea

Mrs. C. H. Willis, Jr., Chairman	Mrs. G. Frank Jones Mrs. John Brittingham
Mrs. M. H. Wylie, Co-Chairman	Mrs. F. Lansing Lee Mrs. W. A. Risteen

Entertainment

Mrs. R. C. McGahee, General Chairman	Mrs. W. S. Flanagan, Luncheon Chairman
Mrs. W. E. Matthews, Co-Chairman	Mrs. Harry Pinson

Timekeeper

Mrs. David Williams, Jr.	Mrs. W. A. Miller
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Exhibits

Mrs. F. A. Kennedy, Chairman	Mrs. C. M. Burpee Mrs. Preston Agee
Mrs. Richard Torpin	

Publicity

Mrs. Walter L. Sheppard, Chairman	Mrs. T. E. Bailey Mrs. Paul Goerner
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Transportation

Mrs. Nathan DeVaughn, Chairman

Pages

Mrs. Stephen Brown, Chairman	Mrs. Neal Yeomans Mrs. Donald F. McRae
Mrs. Wm. F. Hamilton, Jr.	Mrs. Gordon Kelly
Mrs. Joseph Echols	Mrs. William Steed

Hospitality

Mrs. Perry P. Volpitto, Chairman	Mrs. R. L. Rhodes Mrs. E. S. Sanderson
Mrs. Joseph Akerman	Mrs. M. B. Sell
Mrs. W. S. Boyd	Mrs. C. E. Tessier
Mrs. W. R. Burdison	Mrs. Thomas C. Thompson
Mrs. J. H. Butler	Mrs. G. A. Traylor
Mrs. Ralph Chaney	Mrs. W. J. Williams
Mrs. T. L. Clary, Jr.	Mrs. L. R. Tighe
Mrs. W. A. Fuller	Mrs. George H. Ingram
Mrs. Robert Greenblatt	Mrs. C. M. Jump
Mrs. J. R. Kaufman	Mrs. W. A. Gardner
Mrs. R. E. Leonard	Mrs. W. J. Burdshaw
Mrs. J. M. Martin	Mrs. L. P. Holmes
Mrs. L. R. Massengale	Mrs. R. B. Weeks
Mrs. K. W. Milligan	Mrs. J. M. Miller
Mrs. H. G. Mealing	Mrs. J. Phinizy Hitchcock
Mrs. Charles Mulherin	
Mrs. Eugene E. Murphey	

Arrangements

Mrs. J. Phinizy Hitchcock Mrs. W. J. Williams

PROGRAM

Headquarters, Partridge Inn

Registration

Tuesday, April 17, 3:00 P. M. to 6:00 P. M.

Wednesday, April 18, 9:00 A. M. to 12:30 P. M.

Thursday, April 19, 9:00 A. M. to 11:00 A. M.

Program and Entertainment

Tuesday, April 17, 4:30 P.M.—Executive Board Meeting.
Wednesday, April 18, 10:00 A. M. to 12:30 P. M., General Meeting.

Wednesday, April 18, 1:00 P. M.—Luncheon, Partridge Inn Hotel.

Wednesday, April 18, 3:00 P. M.—Tour of Clarks Hill Dam Project.

Wednesday, April 18, Tea (Place and Time to Be Announced by Chairman).

Wednesday, April 18, 8:00 P. M., Public Meeting Medical Association of Georgia.

Thursday, April 19, 10:00 A. M. to 12:30 P. M., General Meeting.

Thursday, April 19 (Time to be Announced), Post Convention Board Meeting.

Thursday, April 19, Joint Banquet, all members of the Medical Association and their wives are invited.

GENERAL MEETING

Partridge Inn

Wednesday, April 18, 1951, 10:00 A. M.

PROGRAM

Call to Order by the President, Mrs. Lehman W. Williams, Savannah

Invocation

Rev. Henry E. Horn, Augusta, Pastor, Lutheran Church of The Resurrection

Pledge of Loyalty

Mrs. Ralston Lattimore, Savannah

Address of Welcome

Mrs. J. Phinizy Hitchcock, Augusta, President of the Woman's Auxiliary to the Richmond County Medical Society.

Response to Address of Welcome

Mrs. William K. Jordan, Macon, President, Woman's Auxiliary to the Bibb County Medical Society.

Introduction of Officers and Honor Guests

Mrs. Ralph Chaney, Augusta

Report of Advisory Committee to the Woman's Auxiliary
Dr. Murdock Equeen, Atlanta, Chairman

Introduction of Past State Presidents

Mrs. Walter G. Elliott, Cuthbert, Councilor of Georgia, to the Woman's Auxiliary to the Southern Medical Association

Report of Meeting of Woman's Auxiliary to the American Medical Association

Mrs. Allen H. Bunce, Atlanta

Report of Meeting of Woman's Auxiliary to the Southern Medical Association

Mrs. John W. Turner, Atlanta

Rules Governing Convention Procedure

Mrs. Bruce Schaefer, Toccoa, Parliamentarian

Introduction of Pages

Mrs. Stephen Brown, Augusta

Report of Entertainment Committee

Mrs. R. C. McGahee, Augusta

*Report of Executive Committee**Report of District Managers**Report of County Presidents**Report of Registration Committee*

Mrs. Malcolm Bazemore, Augusta

*Business**Reading of Minutes**Adjournment***GENERAL MEETING**

Partridge Inn

Thursday, April 19, 1951, 10:00 A. M.

PROGRAM

Call to Order by the President, Mrs. Lehman W. Williams, Savannah

Invocation

Rev. Warren A. Huyck, Augusta, Pastor, First Baptist Church

Pledge of Loyalty

Mrs. C. S. Pittman, Jr., Tifton

*Address**"Looking Ahead"*

Dr. Alpheus M. Phillips, Macon, President of the Medical Association of Georgia

*Address**"Expressions on Organization"*

Dr. W. F. Reavis, Waycross, President-Elect of the Medical Association of Georgia

Address

Mrs. Mason G. Lawson, Little Rock, Ark., Third Vice President, Woman's Auxiliary to the American Medical Association

Address

Mrs. L. S. Thompson, Dallas, Texas, President Woman's Auxiliary to the Southern Medical Association
Memorial Service

Mrs. W. O. White, Jr., Augusta, Chairman

Introduction of Pages

Mrs. Stephen Brown, Augusta

*Reports of Officers**Report of Auditing Committee**Report of Resolutions Committee**Report of Registration Committee**Report of Awards Committee*

Mrs. William H. Benson, Marietta

Mrs. Dan Jardine, Douglas

Mrs. J. Harry Rogers, Atlanta

*Report of Courtesy Committee**Business**Report of Nominating Committee**Election of Officers**Presentation of President's Pin to the Retiring President*

Mrs. Joseph Yampolsky, Atlanta

Announcement by the President

Mrs. J. R. S. Mays, Macon

*Adjournment.***POST CONVENTION BOARD MEETING**

Mrs. J. R. S. Mays, Macon.

RULES TO GOVERN THE CONVENTION

1. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.

2. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.

3. Reports shall not be read from Auxiliaries which are not represented by delegates but shall be filed with the secretary.

4. All original motions on resolutions shall be made by submitting two copies; one to the Resolutions Committee, and one to the Recording Secretary.

5. Reports of delegates and district managers are limited to two minutes.

6. No one is entitled to vote before she is registered.

7. All persons appearing on the program must be seated near the platform when the session opens.

8. Badges must be worn by members of the voting body during all general sessions of the convention.

9. Delegates' privileges are not transferable.

Whispering conversations greatly retard the business of the meeting; order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced. Reports must conform to the time allotted.

PLEDGE

"I pledge my loyalty and devotion to the "WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA." I will support its activities, protect its reputation, and ever sustain its high ideals.

COLLECT

"Keep us, O God, from pettiness; let us be large in thought, word and deed. Let us be done with fault-finding, and leave off self-seeking. May we put away pretense, and meet each other face to face, without self-pity and without prejudice.

May we never be hasty in judgment, and always generous. Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid. Grant that we may realize it is the little things that create differences; but in the big things of life we are one.

And may we strive to teach and to know the great, common Woman's heart of us all, and O, Lord God, let us not forget to be kind."

SAYS DOCTORS WILL BE PREPARED TO PLAY BROADER ROLE IN COMMUNITY

In the future, medical schools will prepare doctors to play an increasingly broader role in the community, according to Dr. Donald G. Anderson, Chicago, secretary of the Council on Medical Education and Hospitals of the American Medical Association.

Writing in the February 17 *Journal of the American Medical Association*, Dr. Anderson said "there are many signs to indicate that without a diminishing of the effort to reduce our understanding of illness to scientific terms, the great accomplishment of the medical schools in the next 25 years or more may well lie in the clearer demonstration and broader interpretation of medicine's role in the community."

Medical schools are leading the way, he pointed out, since the principles, techniques, professional attitudes and ideal of the profession are to a great extent in the hands of the schools.

"In many regions and communities," he continued "the medical schools with faculties of highly trained experts, well equipped laboratories and affiliated teaching hospitals have the outstanding medical personnel and facilities in the entire area. As a result, the schools are being looked to more and more for guidance and active participation in community and regional health programs."

Dr. Anderson pointed to the renewed attention that is being focused on the patient as a whole as one of the most significant demonstrations of this broadening sense of professional responsibility by which the physician concerns himself not only with relief of the patient but his complete rehabilitation as well.

In order to help students to a better understanding of their future responsibilities in the community, he said, medical schools are inviting leaders in medicine, government, labor, industry, farming, welfare work, public health and other fields to meet with the students and present for their consideration what the people in these varied areas expect of physicians in their community.

Dr. Anderson feels that one of the most important tasks in the years ahead will be to provide the students with more information on the different branches of medicine, such as general practice, public health, medical administration, teaching and medical specialties. Many varied opportunities exist in the vast fields of public health alone.

Nor should the medical schools neglect the economic aspects of medicine, he said, including hospital and health insurance programs.

Dr. Anderson said that in advocating this new approach in medical education, he is not suggesting that the period of undergraduate medical education be lengthened or that a large number of special courses be added to the curriculum. What is needed, he said, is a

shift in attitude in the teaching of existing courses to encompass this new outlook. He concluded:

"There is little reason to doubt that we shall continue to see further changes in the years ahead, as the medical schools exert themselves to shape a profession that is prepared and ready to serve the expressed needs of the society that supports it."

REPORT PHYSICIAN PARTICIPATION IN SCHOOL HEALTH SERVICES

A gratifying level of interest, understanding and participation in local school health programs on the part of local medical societies is shown in a survey by the Bureau of Health Education of the American Medical Association, according to the February 17 *Journal of the A. M. A.*

The results of the survey—made under the direction of Donald Dukelow, M.D., and Fred Hein, Ph.D., of the A. M. A.'s Bureau of Health Education, Chicago—were compiled from more than 1,000 returned questionnaires from local medical societies throughout the country.

"In general," the *Journal* said "the report shows that individual physicians and medical societies are active in many aspects of school health services."

The poll revealed these facts:

One third of the medical societies replying have a school health committee. One fourth of the communities have school health councils, almost all of which include medical society representation. More than half of the medical societies report school physicians mostly on a part time basis. Eighty per cent of the communities told of established methods of referring children to a physician through their families.

Procedure by which the family physician can inform the school of a child's special health needs was found in 64 per cent of the communities. Two thirds have modified physical education to meet special needs of pupils, and one fourth provide corrective exercise on medical prescription.

Basic health services for athletes are reported by four out of five. First aid facilities are present in over three fourths, but only one third have complete plans for emergency care.

Exclusion and readmission for communicable disease were found acceptable to school and health officials in 87 per cent of the communities. Only half report reemployment and periodic health appraisal of school personnel.

The U. S. Office of Education, in cooperation with the Public Health Service is now making a companion survey of health services in city school systems of the nation, the article brought out.

The report concluded:

"Since the survey conducted by the American Medical Association, addressed to the county medical societies, has covered the relationship of such societies to the local school health program, the two surveys will provide a rather complete picture of the school health services available to children."

AUREOMYCIN, CHLORAMPHENICOL EFFECTIVE IN MIXED BACTERIAL INFECTIONS

Two Cincinnati physicians report that aureomycin and chloramphenicol—two of the most promising of the newer antibiotics—have brought good results in their treatment of a large number of mixed bacterial infections.

"The results of treatment (on 233 patients) with either of these antibiotics and the indicated surgical procedure were good in a majority of instances, the invasive qualities of the infection being quickly overcome and the local manifestations of the infection disappearing at varying rates," write Drs. William A. Altmeier and William R. Culbertson in the February 17 *Journal of the American Medical Association*.

The doctors are associated with the University of Cincinnati College of Medicine and Cincinnati General Hospital. They explained that lesions produced by mix-

tures of bacteria are especially resistant to chemotherapy and other forms of treatment because of the cooperative action of the infecting bacteria and their tendency to kill tissue and produce extensive abscesses in the abdominal and lung cavities, marked poisoning and progressive spread of the infection. Up to now, treatment of such infections has not been too successful, they said.

In a small number of cases, bacterial resistance to the drugs was noted, the doctors reported, citing 14 cases of resistance among the 179 patients treated with aureomycin and eight cases among the 54 patients who were given chloramphenicol. However, they added:

"There were indications that the efficacy of aureomycin or chloramphenicol in the type of infection in which some of the infecting bacteria were resistant could be increased by the concomitant use of other chemotherapeutic agents to which the organisms were susceptible *in vitro* (laboratory testing)."

The doctors reported little evidence of toxicity in the patients as a result of the drugs.

AUREOMYCIN USED TO PREVENT TOOTH EXTRACTION INFECTIONS

Successful use of aureomycin in reducing bacterial invasion of the blood as a result of tooth extraction is reported by a group of doctors and medical researchers at the Hospital of St. Raphael, New Haven, Conn. This is of particular importance to patients with heart conditions.

Writing in the October issue of *Archives of Internal Medicine*, published by the American Medical Association, the doctors report "twenty per cent of all cases of subacute bacterial endocarditis can be traced to recent dental manipulation."

Drs. Oscar Roth and Robert H. Parrott; A. L. Cavallaro, oral surgeon; and Rose Celentano, medical technologist, made a study of 50 patients. Half the patients (25) received aureomycin; the other 25 remained untreated. Blood tests revealed streptococcus viridans in 14 of the untreated patients but in only one of the patients who received the drug.

Streptococcus viridans is present in the mouth of healthy persons but increases in number with gum infections and dental decay. Defenses of the body ordinarily would destroy the bacteria. However, if the heart membranes have been injured by previous illnesses or disease, often unknown to the patient, the bacteria implant themselves on the damaged tissues.

The report continues:

"For this reason, it is of the utmost importance to eliminate the source of infection in persons with heart disease.

"Particular caution is necessary in these patients prior to tooth extraction or any other dental manipulation, especially when infection is present, in an effort to reduce the high incidence of transient bacteremia following such operations."

Every patient before a tooth extraction should be carefully questioned and examined for certain heart conditions. If such a condition is found treatment should be given to reduce the bacteria, the report advises.

In the opinion of the doctors making the study, aureomycin was given good recommendation because it can be given orally, it apparently does not produce drug-resistant organisms, and it successfully reduces streptococcus viridans.

SIX-POINT PROGRAM IN FIGHT AGAINST TUBERCULOSIS OUTLINED

A six-point program for the prevention of tuberculosis—"the white plague"—is presented in the January issue of *Today's Health*, published by the American Medical Association.

The program, outlined in an article by Dr. J. De Witt Fox of Takoma Park, Md., recommended:

1. Stay away from known spreaders of tuberculosis germs.

2. Watch out for people who cough and spit.

3. Avoid frequent colds and infections.

4. Live a healthful life. Eat a well balanced diet. Get plenty of rest and sleep.

5. Get to know a good doctor. See him whenever you need advice. Have him check your health at regular intervals.

6. Beginning in your teens, have a chest x-ray each year. This is the best way to find tuberculosis early.

Dr. Fox pointed out that for centuries tuberculosis was a leading cause of death in Europe. As recently as 1900 it was the most frequent cause of death among Americans, killing about 200 per 100,000 population. Since then it has declined gradually as a cause to eighth place with a mortality rate of 30 deaths per 100,000 population.

He ascribed this decline as "largely due to the unrelenting efforts of physicians, nurses, public health workers and a well-informed public."

He pointed out that while some drugs have been found that hold promise in the cure of the disease, the best weapons still are prevention and early treatment.

"Because tuberculosis is a contagious disease, one should avoid contact with people known to have it in active form," he advised. "This includes even our dearest relatives; tuberculosis plays no favorites. The disease is spread by germs carried in the sputum of a person with active tuberculosis. The important thing in control is to prevent drops of sputum or dust containing the germs from reaching others."

He said tuberculosis is likeliest to develop when bodily defenses are temporarily weakened by fatigue or stress. He urged extra rest and sleep after recovery from a cold or other infection. Other recommendations were a well-balanced diet, plenty of water, cleanliness, fresh air, outdoor exercise and sunshine. Periodical chest x-rays, he said, will reveal tuberculosis in its early stage when early cure is possible.

NEW TEST GIVES WARNING OF BLEEDING TENDENCY

Hemophilia—a lack of clotting substance in the blood—is not the rare, mysterious and uncommon disease people believe it is, a Milwaukee physician writes in the January 6 *Journal of the American Medical Association*.

Hemophiliac patients—so-called bleeders—, said Dr. Armand J. Quick, of Marquette University School of Medicine and Milwaukee Children's Hospital, need not be left to the care of specialists but usually can be cared for by the family doctor. A new test—called prothrombin consumption test—is proving valuable to the doctor by warning him that a hemophiliac condition exists in certain patients.

"Although the diagnosis is generally easy when the condition is severe," said Dr. Quick, "difficulty is apt to be encountered when the bleeding tendency is not pronounced and the family history is negative for hemophilia."

"In a surprisingly large number of hemophiliacs," he continued, "no positive family history is obtainable." (This condition is known to be both congenital and hereditary).

He cited Queen Victoria as a notable example of a carrier but whose family history appears "entirely negative." It was pointed out that the defect can pass silently through several generations of women. It is also known that a male may have the disease in such a mild state that it may be considered "subclinical," and yet he will transmit the defect to his daughters. The severity of the disease in offspring is unpredictable.

According to Dr. Quick, abnormal bleeding after tooth extraction or a minor operation is sometimes the first sign, and in some cases the only sign, of a bleeding tendency.

"A considerable number of hemophiliacs," he continued, "have the disease in such a mild form that

they rarely require medical treatment and even those who have moderately severe hemophilia may be free of hemorrhagic episodes for relatively long periods."

Bleeding into joints usually occurs for the first time after the child begins walking and engages in relatively strenuous games. Such a condition generally denotes "moderately severe" hemophilia, he said.

The application of cold (an ice bag), the use of a pressure bandage, if the site of the injury permits, and complete rest of the joint were named as three essentials for immediate treatment following injury.

Dr. Quick pointed out that contrary to popular belief the most important danger in hemophilia is not loss of blood but the development of various lesions caused by pressure of tumor masses (which consist of collections of blood) and bleeding into the joints.

"Many hemophiliacs are crippled because joints were neglected after hemarthrosis or because contractions occurred after hemorrhage into a muscle," he said.

"Much of this problem is in the domain of the orthopedic surgeon, but if the parents of a hemophiliac child are properly educated and have the service of a family physician who handles the emergencies much can be accomplished in saving the hemophiliac from becoming a cripple."

HEALTHGRAMS

Every mother of a family, and every doctor in practice, firmly believes that the best bulwark against infection is good wholesome food. The association of tuberculosis with poverty and malnutrition is particularly noteworthy. Editorial, *Lancet*, December 24, 1949.

* * *

In various forms—whether poliomyelitis, tuberculosis, cardiovascular disease, diabetes or any of the other abnormalities that are likely to alter a patient's social and economic activities—these chronic conditions account for three fourths of all illness today. Progressive control of infectious diseases and the increasing number of elderly people in the population are bringing about a situation in which the chronic illnesses and preventive medicine may in the future demand the entire attention of physicians. Editorial, *New England J. Med.*, August 10, 1950.

* * *

In more than one country in the world, in recent years, carefully planned studies into infection and morbidity rates have shown clearly that the incidence of clinically significant tuberculosis is far in excess of that which is compatible with the death rates as returned officially by the same communities. Official Records of the World Health Organization, No. 18.

RAPID GROWTH OF VOLUNTARY HEALTH INSURANCE REPORTED

Voluntary health insurance is spreading so rapidly that a coverage of 90,000,000 Americans against the major costs of illness should come within the next two or three years, said Dr. Elmer L. Henderson of Louisville, president of the American Medical Association.

Writing in the January 27 *Journal of the American Medical Association*, Dr. Henderson said that between 70,000,000 and 72,000,000 people now have some form of voluntary health insurance.

Dr. Henderson, in reporting the rapid growth, said the second Blue Shield medical care plan, the United Medical Service, operating in the New York metropolitan area, has just passed its 2,000,000 mark in enrolment. The first plan to reach that figure was the Michigan Medical Service. He said further:

"Together, the achievements of these two great medical care plans illustrate dramatically the eternal truth which some of our detractors would deny—that voluntary health insurance is a growing, successful, practical method of taking the economic shock out of illness.

"The United Medical Service, for instance, has reached its present size in six and one-half years. It operates in

the 17 southern counties of New York State, with the active approval of the Medical Society of the State of New York and of the medical societies in those 17 counties. Half a million members were gained during 1950—one fourth of the total enrolment. The goal for the next year or year and a half has been set at a further increase of 1,000,000 members.

"It is pertinent here to cite some figures showing the remarkable growth of the nonprofit medical care plans over the nation. There now are 72 Blue Shield plans in 41 states. Participating in their operation are 113,000 out of the 150,000 physicians who are in active, private practice. Last year the Blue Shield plans paid out \$150,000,000 for surgical and medical services rendered to member patients; this at the rate of 82 cents of every dollar paid in premiums.

"The Blue Shield plans are enrolling members at the rate of 28,000 every working day, and they now protect approximately 12 per cent of the population—more than 17,000,000 persons. Other nonprofit medical care plans not yet in the Blue Shield group cover an additional 2,250,000 persons. During 1950 the Blue Shield plans of the nation gained 5,000,000 new members, an all-time record growth.

"The Blue Cross hospital plans kept pace. They added more than 3,000,000 new members in 1950, carrying them beyond the 40,000,000 mark in total enrolment. Out of every premium dollar, Blue Cross plans are paying out close to 88 cents in benefits for services to their member patients.

"But the spirit of competition, of improvement, is by no means confined to the nonprofit medical care plans. Final and complete figures from the insurance companies and the various other agencies in the health insurance field will not be available for several months, but it is a conservative estimate, based on all known developments in 1950, that between 70,000,000 and 72,000,000 Americans now have some form of voluntary health insurance coverage."

NEW BIOGRAPHY OF GENERAL GORGAS PUBLISHED. Alabama's famous son, William Crawford Gorgas, has recently been elected to the Hall of Fame. Although his name is not so familiar to this generation, Gorgas was known throughout the world before his death in 1920 for his work against diseases, particularly yellow fever.

The Duke University Press published on November 15 *Physician to the World: The Life of General William C. Gorgas*, by John M. Gibson, Director of the Alabama State Health Department's Division of Public Health Education.

From the time "Willie" Gorgas set his toy cannon on his Richmond, Virginia, housetop and aimed it at the oncoming Yankees until some fifty-five years later, when on his deathbed he received the insignia of the Order of St. Michael and St. George from King George V of England, he was a fighter. Called by many "the man who made the building of the Panama Canal possible," Gorgas is remembered today only as the sanitarian. *Physician to the World* brings the man back to life. Drawn from personal correspondence of Gorgas and his family, this is a heartwarming story of a little boy who shivered in the early morning air of Charleston as he watched the first shell explode over Fort Sumter; of a young man whose determination to enter the Army led him to medical college because the only road left open for entrance was through the Medical Department; of an Army physician who, disregarding personal danger, deliberately entered a yellow fever ward to study the disease; and of the romance of a doctor who married one of his patients. It is the success story of the Sanitation Officer of Havana, Cuba, where the yearly deaths from Yellow Jack dropped from five hundred to zero; and the story of the disillusionment of a man who tried to make the Panama Canal area safe for workers and their

(Continued on Page XVI)

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THE PHYSICIAN'S RESPONSIBILITY

A. M. PHILLIPS, M.D.

Macon

In the past few years we of the medical profession, in the interest of preserving the high standards of American medicine, have emphasized our rights. Today I want to speak of our responsibilities. The breakdown of understanding between the physician and the patient, the insidious encroachment of government in the field of medicine, and the crisis brought on by the challenge of Communism to Democratic freedom demand that we define anew, by self-examination and the fine art of self-criticism, our responsibilities as professional men and as citizens.

The Physician's Responsibilities to His Patients

The breakdown of the sympathetic relationship between physician and patient calls for a review in the first place of those traditional responsibilities which we owe to our patients. The fact that these responsibilities are so taken for granted that they have become commonplace is all the more reason for a critical re-evaluation and analysis of the doctor-patient relationship.

Our primary obligation is to the patient. Our obligation to the profession has significance only as it is a means of serving the patient. Our first obligation to the patient is that of giving him our *time* and our *undivided* attention. We must take the

time to understand the complete picture of his condition, and to explain to him the causes of his symptoms and the reasons for the proposed treatment. We are not magicians, we are physicians; and our patients—except the very youngest of them—are people capable of understanding the general nature of their condition and of the treatment we propose. To surround our practice with an aura of mystery is a technic that belongs to the cults.

Furthermore, we owe it to our patients to keep our skill at its peak by practicing, in our own expenditure of physical and mental energy, the moderation which we preach to them, and by utilizing the cultural and spiritual resources afforded by wholesome recreation, reading, home life, and worship. An extensive practice is exhausting; and when we become overtaxed our medical judgment wavers, our patients are denied their rightful consideration, and we become guilty of that assembly-line type of treatment which we so greatly deplore in England.

Another obligation to our patients as well as to ourselves is that of keeping abreast of medical progress, particularly in our special fields of interest. Such alertness is one of the keys to better public relations. Failure to utilize new treatments opens the profession to criticism on the part of patients. On the other hand, the effective use of new technics and new drugs restores the confidence of the patient in our skill and in our concern for his well-being.

Several years ago the wife of a friend of mine, who has been somewhat skeptical of the attitude and practices of contemporary

President's address before the public meeting of the Medical Association of Georgia, 101st annual session, Augusta, April 18, 1951.

medicine, became critically ill with virus pneumonia. A local internist, after giving penicillin an unsuccessful trial, prescribed the then new drug, aureomycin, with excellent results. My critical friend, belonging to the intellectual class, was not impressed by our propaganda on socialized medicine; however, he did appreciate the skillful and intelligent application of a new medical discovery by his wife's physician. It is on the basis of such appreciation that new bridges of understanding can be constructed between patient and physician.

We must maintain an open-mindedness which will welcome any addition to medical knowledge from whatever source, and we must not let inertia and the chains of habit bind us to methods of diagnosis and forms of treatment which are outmoded. Here, however, the Aristotelian dictum of the "Golden Mean" is appropriate. New methods of treatment which are developed should be received critically and tried cautiously until their value and safety have been proven in use. "Be not the first by whom the new is tried, nor yet the last to cast the old aside."

The Physician's Obligations to the Medical Profession

The physician's obligations to his patients and to the profession are so closely interrelated that any attempt to separate them is likely to be artificial. However, I should like to point up certain duties which we owe to the profession and which, as I see them, need re-emphasis. In this brief time I cannot attempt to cover the total obligations we have to our colleagues, but I will mention four of the most vital. These are: (1) the advancement of medical knowledge, (2) duties that relate to medical education, (3) participation in medical organizations, and (4) the responsibility of the profession within the framework of society.

Advancement of medical knowledge. The advancing of the frontiers of medical knowledge is the responsibility and the privilege of every practicing physician. Let us not be overawed by the impressive equipment and achievements of research done in medical centers, but let us use our own powers of observation to recognize unusual cases and our own knowledge and skills to devise new methods of treatment to meet the needs of a particular case.

Some of the greatest advances in medicine have been based on *clinical* research—research done at the patient's bedside with the aid of nothing more than the doctor's five senses and the instruments in his handbag. William Harvey's contributions to our knowledge of the circulation, Beaumont's study of gastric secretion, Crawford Long's discovery of ether as an anesthetic—all these represent advances in medical knowledge which were made without the aid of government grants and expensive equipment.

Unfortunately, many original observations in medicine perish with their discoverer simply because the physician lacks the time, energy, or courage to put them into writing and to submit the articles to a medical journal for publication. Procrastination is not only the thief of time; it is also the thief of medical progress. In failing to share with our fellow physicians our discoveries and observations of unusual cases, we retard medicine.

We must overcome the inertia and the timidity which prevent us from setting our findings down on paper. Because Marion Sims thought that he was unable to express himself in writing, he almost missed his chance of fame and the world almost lost the benefit of his great surgical discoveries. Providentially, it seems, a friend of his was led to uncover a magazine containing a case report written by Sims. The friend's words

of praise for this report (which Sims had hidden because he was ashamed of its style) encouraged the young surgeon to publish other articles describing his brilliant and original technics.

Duties related to medical education. Closely allied to our responsibility for the advancement of medicine are our duties that relate to the education and training of future physicians. Those of us who took the Hippocratic Oath swore "to impart to . . . the disciples who have enrolled themselves . . . the precepts and the instruction." Interpreted in the light of modern times, this oath makes plain our obligation to maintain an interest in the training of physicians and to support the institutions which make this training possible.

It seems to me that our present plight in public relations may be attributed in part to the fact that our *premedical* training was restricted, in the main, to the sciences. A physician in these times of transition must be more than a competent technician. He must have a truly liberal education, which will equip him to think logically, read intelligently in all fields, and express himself clearly, forcibly, and persuasively. Some acquaintance with music, art, and literature not only affords the physician a great deal of satisfaction during his short periods of leisure, but also broadens his interests and sympathies. Studies in economics, sociology, and political science are essential in order that some insight into social problems and the technics of political action might become part of the equipment of the future physician.

Since privately endowed and church-related colleges in this country have been most zealous in advocating the type of liberal education I have described, we would do well to support and encourage these private institutions in every way possible. Thus we will not only assure the liberal

tradition in premedical studies, but will also help to maintain the balance between private and government-sponsored education.

In the field of medical education itself, we are under strong pressure from two sources to increase the number and capacity of our medical schools. A health-conscious public is demanding more doctors, and qualified young men with a burning ambition to study medicine are begging for admission to these institutions. The medical profession, if it is to maintain the high standards it has set for itself, must explain to the public why hundreds of young men with all the necessary qualifications are rejected by medical schools each year, while Mrs. Brown is unable to get a doctor to come to see her child who has a fever of 103 F. We must make it clear that part of the trouble, at least, is due to faulty *distribution* of doctors, and that small towns and rural areas must do their share to attract medical graduates by providing reasonably adequate office facilities for their use. Our medical schools must stem the tide toward specialism and the concentration of physicians in large cities by emphasizing the advantages of general practice in small towns and de-emphasizing the necessity for complicated laboratory technics in diagnosis and treatment.

If an actual shortage of physicians does exist—and certainly those of us who fought the last war on the home front cannot doubt that another all-out war would inevitably precipitate an acute shortage—the medical profession should take the leadership in seeking means to train more doctors *at once*. Otherwise the government, capitalizing on the discontent of the people and recognizing the necessity for keeping the doors of opportunity open, will assuredly use the present emergency as an excuse to dominate the field of medical education and, after

that, medical practice. The American Medical Association has opened the campaign by establishing a fund to assist medical education. In addition to contributing to this fund, we would do well in our local medical societies to establish scholarships and revolving loan funds to aid qualified students who desire medical training but are unable to finance it.

If all our efforts do not suffice to prevent the government from encroaching further on the field of medical education, we should recognize this danger in time to effect a compromise. Somehow we must see to it that the responsibility for setting medical standards is left in the hands of the profession, and that authority for the distribution of government funds to aid medical education is given to the individual states.

Participation in medical organizations. The perennial weakness of any democratic organization is the failure of individual members in their responsibility for keeping the organization democratic by participating actively in its affairs. The American Medical Association is organized on a democratic basis, and local and state medical societies, patterned on the principle of the parent organization, reflect the democratic structure. A democratic constitution, however, whether in the United States or in the Medical Association of Georgia, does not assure a democracy unless each citizen and each member of the Association participate. What happens is usually this: We elect those men who will assume positions of leadership, leave them with the full responsibility for carrying on the work without any suggestions on our part, and then call them dictators when we don't agree with them. Participation means more than writing the annual check for dues. We should participate not as rubber stamps for the current party line, but as free physicians and individuals who do their own thinking

about the complex and numerous problems that confront the medical profession. If our organizations are to remain truly democratic, it is necessary that every opportunity be given for the free expression of divergent opinions and viewpoints within the profession.

Responsibility for interpreting the profession to society. The practice of medicine in a complex civilization is not an isolated art. For good or ill, it is interrelated with the business structure, with the other professions, and with politics. Each of these fields is highly specialized, and the average physician finds himself perplexed when he attempts to relate his individual practice to this larger environment. No longer can the responsibilities of a physician be discharged by competent practice and ethical relations with his colleagues. He must make decisions on other levels and in other fields. These decisions call for wisdom, social awareness, and some familiarity with the sciences of sociology, economics, and government, in order that we may understand the complexities of our civilization, the dynamics of social change, and the technics of political action.

Not only must we study society, we must also interpret to society the viewpoints of our profession on the questions of socialized medicine, federal aid to medical education, and health insurance. Whether we like it or not, the facts are that thousands of people are dissatisfied with the medical care they are receiving, and that the profession's public relations are at low ebb. We recognize that many of the criticisms made against the medical profession are unjust, biased, government-inspired, and often the fulminations of psychopathic patients; but with all this smoke there must be some fire. It is possible that we physicians, given to human frailties like other men and women, have confused our desire for personal advantage

with our ideals of maintaining high standards of medical practice. Physicians who are reluctant to make calls to see patients should not be surprised to find that unfavorable propaganda is taking effect.

A year or so ago one of the state medical societies had at its annual meeting an exhibit which invited the members to come in and meet "the best public relations man the medical profession has." Doctors entering the booth came face to face with a large mirror. What a forceful way of getting across a vital truth! Every time you look at yourself in a mirror, you should be reminded that, for your patients, *you* are the medical profession. Your concern for their welfare, your self-sacrificing service to them, and your ethical relations with your colleagues will have more weight with *your* public than full-page advertisements in every newspaper in the country. It is up to you, not to the professional public relations experts hired by medical organizations, to interpret the views of the medical profession to the public, and to prove to them our sincere desire to give them the best medical care possible under any conditions.

Forces of social change demand adjustment. Our Democracy is founded on the faith that the opposing principles of individual freedom and the common good can be reconciled by constitutional, representative government. When any group in the pursuit of its own interests makes mistakes which are either detrimental to the common good or so interpreted by the people as detrimental, punitive legislation is the result. For example, the Sherman Antitrust Act and the Taft-Hartley Law.

As individuals and as a group, we make our mistakes. We see now that we were a little slow on the uptake in recognizing the importance of voluntary health insurance, which we now sponsor. We should take seri-

ously the plight of patients in the low income group and support the Georgia plan of voluntary medical insurance now being sponsored by our Association. In this connection, let us consider the suggestions made by Frank G. Dickinson of the Bureau of Medical Economic Research of the American Medical Association concerning plans for voluntary health insurance covering catastrophic illness, and his recommendation for "an indemnity policy which a wage earner could pay for during his working period of life and which after age 65 would provide a paid up 'medical care annuity' for the rest of his life."

If conditions in the practice of medicine demand reform, one thing is certain: we must do our part to protect the public welfare.

Responsibilities of Citizenship

As the servants of medicine—the jealous mistress—we physicians tend to leave social, political, and international problems to the sociologists, the politicians, and the diplomats—that is, until an issue like compulsory health insurance startles us into political action.

Now, however, the world-wide threat of godless Communism abroad and the bitter conflicts of partisan groups at home endanger not only our democratic way of life, but life itself. The responsibilities of a citizen in a Democracy are a full-time job, and political participation ought not be limited to those crises when personal interest is involved.

Our profession has an honorable record to uphold, as far as intelligent and courageous participation in larger social and political issues is concerned. John Locke, an English physician, in his *Two Treatises on Government* laid foundations for later American Democratic thought; Dr. James McClurg, Virginia-born, with a medical degree from the University of Edinburgh, was

a delegate to the convention which drafted the Constitution of the United States. In the present, all of us are aware of the splendid public service record of the congressman from Minnesota, Walter H. Judd, M.D.

Since the mantle of world leadership among freedom-loving peoples falls on the United States, her citizens must develop a world outlook to match this responsibility. Public opinion has a tremendous impact on foreign policy, and unless that opinion is informed and active our country can easily make suicidal blunders. An all-out war with Russia could result either in transforming our country into a welfare state or in destroying our present civilization entirely, thereby throwing medicine into another dark age. One way to prevent overt conflict with Russia is to strengthen Democratic governments when they face crises which give the Communists a fertile field for propaganda. We flood Washington with letters explaining our position on socialized medicine; how many letters have we written urging the grant of wheat to the starving people of India? We ignore these larger issues at our own peril.

On the home front, momentous problems test the Democratic way of life daily. Inflation, the breakdown of public morality as evidenced by the Kefauver report and the investigation of the R. F. C., the loss of personal liberties, new tensions between Church and State, the race problem, and the struggle between capital and labor—all call for decisions that, in the final analysis, must be made by the citizens of this country.

As citizens we must think these tough problems through, translate our conclusions into political action. Above all, we must guard against attack from the extreme left, which leads to the welfare state; and attack from the extreme right, which leads down the dark road taken by Hitler, Franco,

Mussolini and Peron. Communism's greatest threat within the United States is that it will force us to take hysterical steps leading to Fascism. Although I do not necessarily approve the political viewpoints of Maryland's Mr. Tidings, the dishonest and cowardly smear methods used to defeat him strike at the very foundations of our Democracy.

I urge you to give zealous attention to the defense of freedom in your home town. When personal rights are ignored, when mob violence erupts, when freedom of assembly is denied, we as citizens have a job on our hands. When my neighbor's house catches fire, my home is in danger; when my neighbor's personal freedom is denied, my liberty is jeopardized.

Beyond the question of freedom lies the ultimate question of faith. In the final analysis, a man is what he believes. Dr. Alexis Carrel, Nobel Prize winner, in his book *Man the Unknown* reminds us that we cannot escape these final questions of philosophy and religion. The last fight with Communism is not in the realm of economic theory, but in the realm of faith. I know that a man's religion, like his taste in neckties, is a personal matter; but in these days when civilization is cracking and the center of personality disintegrates in the acid of skepticism, the luxury of neutrality on the question of faith and morals is no longer possible even for physicians.

We know how to apply the fine art of self-criticism to our practice of medicine—but have we the courage and ability to apply it to our personal lives, to confess our faults, and to assume our responsibilities to our patients, our profession, our Democracy, and our religion? To myself as well as to my listeners I say, "Physician, heal thyself," for ours is the sickness of a civilization that has lost its way. In our healing lies the recovery of spiritual health by

which the sacred art of healing flourishes, and the recovery of those principles by which free man in his hour of decision can see to it that the somber shadows of the present descend not into the darkness, but fade into the dawn.

PRESENTATION OF THE PRESIDENT'S
GOLD KEY TO ALPHEUS MAYNARD
PHILLIPS, M.D.

CHAS. H. RICHARDSON, SR., M.D.
Macon

Mr. Chairman, Dr. Phillips, Members of the Medical Association of Georgia, Distinguished Guests, Ladies and Gentlemen:

From two points of view alone has a man a wide and satisfactory perspective of the organization of medicine—one as he starts a year of service at the foot of the hill, eager for the journey; the other wider and perhaps less satisfactory, as he gazes from the summit and looks back upon the work he has done, and the reflection that he gets in the lengthy shadows cast by the rays of the setting sun.

So on this occasion we shall look back for a moment upon the year which has passed, and see what traits the man we are to honor tonight has shown that make his administration of value, and what results his sustained zeal and enthusiasm for organized medicine have accomplished.

When he came to office a Public Relations Department had been established by his predecessor, but it had never really begun to function and was falling apart at the seams. With force and determination he took the tangled threads of this fabric and wove them into a pattern of unity and smoothness. Today the Medical Association of Georgia has a Public Relations Depart-

ment that has found favor with its friends of the press, the radio, and is creating an enviable amount of good will with the public at large. It has had a large and useful part in the general program of bringing to the attention of the citizens of the State in no uncertain terms that Socialized Medicine is no bargain. That to my mind is worth while.

At the beginning of the year a prepayment plan for medical care for the low income group had been worked out by a painstaking and splendid committee, but it could not be put in operation; because through either indifference or misunderstood opposition, it had not received the necessary approval of a percentage of our members.

Our President took up the challenge and went over the State, and with patience, spirit and kindly disposition he explained the workings and importance of this plan, realizing probably its shortcomings, but pleading the importance of a start, and promising that with experience and trial, the errors could and would be corrected.

As a result of this, the plan has now been fully approved by our Association and the laws of our State, and is being rapidly put into operation.

This is another answer to those who would tell us that only the State can provide medical care for the low income group. This to me is distinctly worth while.

For many years we have stumbled along with the Constitution and By-Laws which originated in the horse and buggy days and which we had outgrown. Other attempts at revision had been made, but had been rejected or voted down by our governing body, the House of Delegates.

Realizing the importance of this, and willing to make one more attempt at something which some of our members said was impossible and others said could not be done, he appointed a committee which un-

der the able guidance of Dr. Allen Bunce, Chairman, went to work, and gave us a revised and modern edition of the Constitution and By-Laws which will greatly facilitate our work and action. This again I think is worth while.

So these three things are outstanding achievements of the man we honor tonight, and I think you will agree that the record speaks for itself.

You will note that I have said nothing about the personal life and background of this man. These to me are of little importance. It is the things a man does that counts on the record.

For better or worse, there are few occupations of a more satisfactory character than the practice of medicine, if a man can bring to it the philosophy of honest work, the philosophy that insists that we are here not to get all we can out of life about us, but to see how much we can add to it.

On this basis, Mr. President, and on the record of a job well done, I am pleased and honored to present to you, on behalf of the Medical Association of Georgia, this Badge of Service—a Gold Key.

THE MANAGEMENT OF URETERAL OBSTRUCTION IN CHILDREN

PETER L. SCARDINO, M.D.

Savannah

The purpose of this presentation is to discuss a method of surgical management of ureteral dilatation in children. While the method has been employed primarily in a limited number of cases of ureteral pathologic change secondary to congenital bladder neck obstruction, the technic can be recommended for the reconstruction of the

dilated ureter secondary to other causes.

Having observed cases of ureteral dilatation secondary to lower urinary tract obstruction which failed to respond to removal of the lower tract obstruction, we were stimulated to undertake this investigation. In spite of Hinman's exhortation: "Ureteroplastic repair often is indicated when markedly tortuous and dilated ureters are present, adhesions having formed so as to lead to the production of functioning valves at the angulations," a review of the literature reveals the procedure to enjoy little popularity. Urologic studies indicated that the dilated, tortuous ureter was a reservoir of infected residual urine, which resulted in the production of progressive hydronephrosis. When simple relief of the vesical neck obstruction failed, satisfactory response seemed to depend upon removal of the ureteral obstruction itself as well as the initiating factors.

This method of ureteroplasty was initially employed in the treatment of infants and children who presented a syndrome previously described by Osler,⁶ McClendon⁷ and others⁸. The syndrome comprises bilateral cryptorchism, pigeon breast, and a markedly protuberant abdomen with readily palpable viscera through thin flaccid abdominal muscles. The history usually revealed obstructive urinary symptoms. Urologic studies showed valvular obstruction of the prostatic urethra and/or congenital contracture of the bladder neck. This obstructive uropathy resulted in an atonic bladder, dilated, tortuous ureters, hydronephrosis, urinary tract infection and ureteral reflux. Chemically, the obstructive uropathy reflected itself in azotemia, acidosis, anemia, and renal failure.

The urologic picture just described is not uncommon except when associated with the unusual abnormality of pigeon breast, atrophic abdominal muscles, and bilateral

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Fig. 1, J. A. T., Case 1. Thirty minute post injection I. V. P. on Aug. 10, 1948 showing hydronephrosis, hydro-tortuous ureter, right. Poorly functioning left kidney.



Fig. 2, J. A. T., Case 1. Cystourethrogram showing urethral obstruction and a distended bladder.



Fig. 3, J. A. T., Case 1. Forty-five minute post injection film on June 2, 1949, shows a straightened ureter with some decrease in the hydronephrosis. The left nephrostomy and cystostomy drains were still in situ at this time.

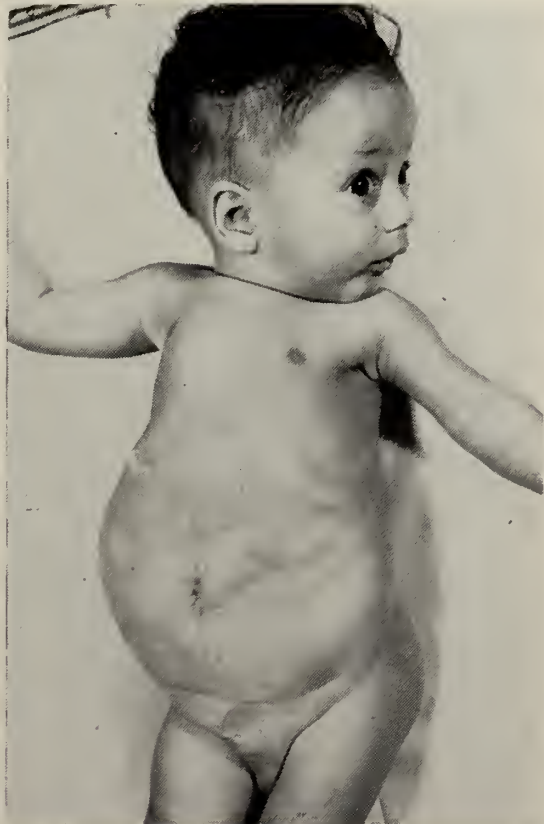


Fig. 4, R. D., Case 2. The child, aged 5 months, showing flaring of the ribs, pigeon breast, protuberant abdomen, atrophic abdominal wall and bilateral cryptorchidism.

cryptorchism. This chest, abdominal and genital abnormality is thought to be the direct result of in utero lower urinary tract obstruction. Embryologic studies have re-

vealed that urine passes through the urethra early in the ninth week. At approximately

the same time the muscle sheets formed by the ventral down growth of myotomes have grown around anteriorly constricting the opening of the umbilical sac. Since urine does not begin to flow through the urethra until the ninth week, urethral obstruction could play no part in the production of renal damage until this time. However, once other exits for the escape of urine have closed, any obstruction to urinary outflow through the urethra will result in bladder distention with subsequent hydroureter and hydronephrosis. The distended bladder exerts pressure on the already formed abdominal muscles causing anemia and death of muscle fibers. The remains of rectimuscle above the umbilicus is due to the great protection from pressure afforded to its blood supply. The enormously distended bladder also prevents the descent of the testes which normally occurs in utero during the seventh month^{6,9}. Four case studies are presented to illustrate the results of ureteroplasty.

This study includes two patients with lower urinary tract obstruction associated with abdominal muscular atrophy; one case of lower urinary tract obstruction and urachal cyst, and one case of ureterovesical juncture obstruction which resulted from extrinsic pressure exerted by a herniated loop of rectosigmoid in a child with imperforate anus.

Surgical Management

The method of ureteroplasty is similar in all cases. Satisfactory renal function is established by nephrostomy. Satisfactory antibiotic blood levels achieved. Chronic anemia is corrected. Ureteroplasty is then undertaken in the following manner.

The ureter is isolated along its entire course through the usual flank and abdominal approaches. The periureteral structures are separated from the tortuous organ. Frequently encountered are rather large ar-

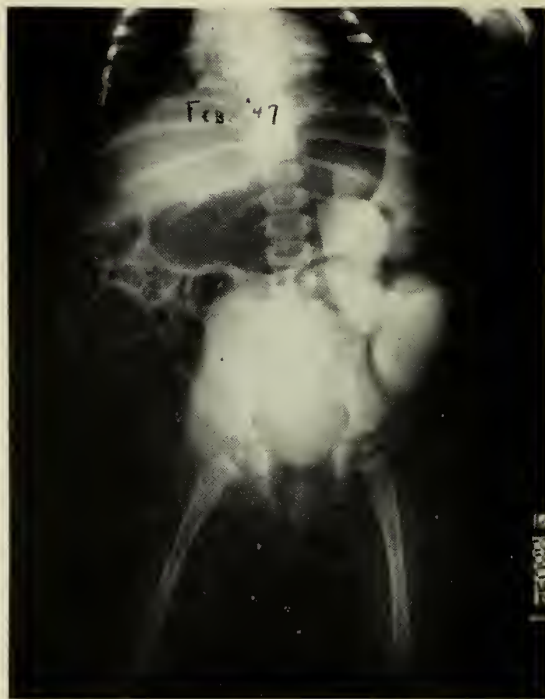


Fig. 5. R. D., Case 2. Delayed post injection pyelogram revealed an enormous bladder, a dilated, tortuous ureter and marked hydronephrosis, left. The right kidney and ureter had been removed.

teries and veins, supplying segments of the dilated ureter. An effort is made to save as much of this blood supply as possible. Redundant portions of the ureter are sacrificed in such a manner as to permit a straight tube from the renal pelvis to the bladder. The caliber of this straightened ureter is reduced by longitudinal dissection of the redundant tissue. The remaining ureter is sutured over a splinting tube of either red rubber or polythene utilizing four zero chromic catgut. If ureteral reflux has been demonstrated, and if the blood supply to the remaining ureter is such as to warrant an anastomosis, the distal end of the ureter is reimplanted into a new bladder site¹. If reflux has not been demonstrated, and the blood supply required dissection of the mid portions of the ureter, an end-to-end ureteral anastomosis is performed in the usual fashion. In case No. 2 the blood supply and previous surgery at the ureteropelvic juncture, required ureteropelvioplasty. After the caliber of the ureter



Fig. 6, R. D., Case 2. The excised portion of the left ureter revealed one portion 12 cm. x 7 cm. at the widest point.

is reduced to size 8F and the neoureterostomy performed, the splinting tube is brought out superiorly adjacent to a nephrostomy tube, and distally adjacent to a cystostomy tube. The wound is closed in the usual fashion.

The postoperative care includes fluid and electrolyte stabilization; continuation of extensive antibiotic and chemotherapeutic agents and the maintenance of patency of all drains. The splinting ureteral catheter is removed in four or five weeks. Prior to removal of the nephrostomy drain, a retrograde pyelogram is made via the nephrostomy tube, and if a patent ureter is demonstrated the nephrostomy drain is removed. Removal of the cystostomy tube follows satisfactory surgery of the urethral obstruction and return of vesical tone.

REPORT OF CASES

Case 1. J. A. T., J.H.H. 306734. An 11 year old white male, was born with a distended abdomen associated with atrophic abdominal muscles, pigeon breast, undescended testes, and urinary tract obstruction. Early investigation revealed severe upper urinary tract damage, which resulted from prostatic urethral valves. At the age of 3 years suprapubic cystostomy and a Young's punch operation were performed. Permanent cystostomy drainage was instituted at this time. Urinary studies during the ensuing four years revealed progressive hydronephrosis, hydroureter, retardation in growth and development, and gradually increasing azotemia and acidosis. At 8 years of age, in August 1948, examination revealed an underdeveloped and undernourished child with obvious pallor who had a moderate azotemia, acidosis, and hypocholemia. The blood pressure was within normal limits. Urologic studies revealed right hydronephrosis, marked, right ureteral dilatation and tortuosity, left renal hypoplasia, left ureteral dilatation and tortuosity; Fig. 1 ureteral reflux and a dilated atonic bladder with a capacity greater than 600 cc., Fig. 2. Urethral valvular obstruction was observed cystoscopically. Bilateral nephrostomy was performed on August 13, 1948. The PSP test, collected via the nephrostomy tubes, revealed 70 per cent excretion from the right in two hours and 8 per cent from the left. On August 23, 1948 ureteroplasty, right, neoureterostomy, right, and cystostomy were performed. Twelve centimeters of dilated ureter was excised. The pathologic diagnosis of the excised portions of the ureter was: chronic inflammation and muscle hypertrophy. The postoperative course was uneventful. The cystostomy drainage was continued for 18 months. Intravenous



Fig. 7. R. D., Case 2. Twenty minute post injection film shows good concentration of the contrast media with some reduction of the hydronephrosis. The ureter remains relatively straight.

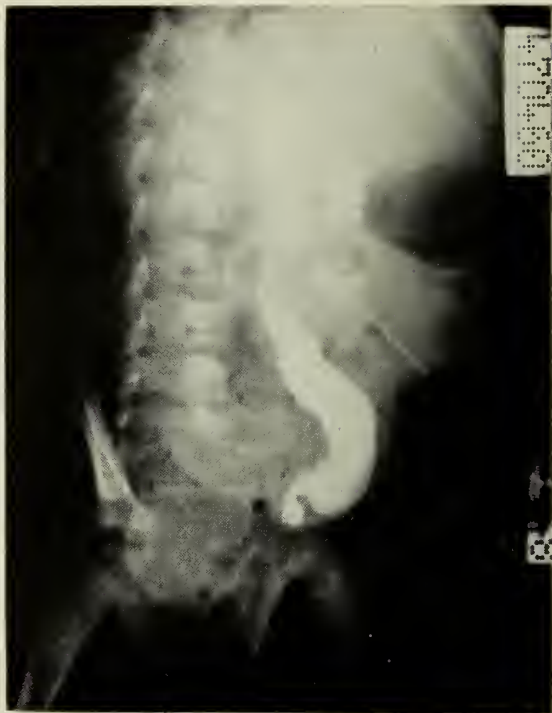


Fig. 8. F. P., Case 3. Injection of contrast media via the left nephrostomy reveals hydronephrosis and hydroureter.

pyelogram on June 3, 1949 prior to removal of the cystostomy tube showed some decrease in the right hydronephrosis. The ureter had remained patent and straight, Fig. 3. During this interim transurethral resection of the obstructing urethral tissue was carried out with the 16F McCarthy resectoscope on June 6, 1949.

On February 11, 1950 cystoscopy revealed a satisfactory transurethral resection had been performed seven months previously, and that the bladder tone had finally returned. The blood chemistries were normal. The bladder capacity was 400 cc. and the patient voided satisfactorily without residual urine.

Case 2. R. D., J. H. H. 392956. This child was four months of age when first observed on August 5, 1946 in the surgical outpatient department. He was not observed urologically until February 1947. Like Case 1, the abdomen was distended; the musculature atrophic. He had a pigeon breast and undescended testes, Fig. 4. Urologic studies at that time revealed right atrophic pyelonephritis, and hydrotortuous ureter; hydronephrosis and hydroureter, left and a large dilated bladder, Fig. 5. Congenital vesical neck obstruction was the etiologic agent. Azotemia, anemia and acidosis were present. Permanent cystostomy was not instituted until August 22, 1947 followed by nephroureterectomy, right on September 8, 1947. One week later pyelostomy drainage was instituted on the left after the patient developed chills, fever and uremia. Subsequent studies indicated failure of visualization of the left ureter when retrograde injection of the skiodan through the nephrostomy drain was carried out. Cystoscopic examination revealed marked ureteral dilatation. Ureteroplasty was carried out on September 15, 1948, after preoperative preparations similar to case 1 had been performed. In addition to the ureteroplasty a ureteropyeloplasty was performed. The ureter, pathologically, revealed chronic inflammation with muscular hypertrophy, Fig. 6. On October 25, 1948, transurethral resection of the bladder neck was carried out. The bladder capacity at that time was 800 cc. The patient was discharged with a permanent suprapubic drain.

Blood chemistries remained within normal limits after removal of the nephrostomy and ureteral catheter. The cystostomy tube has not been removed. A recent intravenous pyelogram revealed moderate decrease in the left hydronephrosis. The ureter remained relatively straight, Fig. 7.

These two cases illustrate the unusual syndrome of obstructive uropathy associated with other congenital abnormalities which are thought to be a direct result of the uropathy. The management of the two cases paralleled each other. Sufficient time has not elapsed for satisfactory evaluation of either case. The only conclusion that can thus far be drawn is one of surgical tolerance on the part of the infant patient and the immediate postoperative evidence which indicates improvement in renal function.

Case 3. F. L. P., J. H. H. 470460. This patient had a birth weight of 4 pounds. His growth and development were very slow. At 8 months of age, on July 8, 1948, he was noted to have abdominal swelling. Cystoscopy revealed 360 cc. residual urine, a trabeculated bladder and soft obstruction of the prostatic urethra with an irregular vesical orifice. Urologic studies revealed bilateral hydronephrosis, hydrotortuous ureter, and an enormous bladder. The laboratory studies revealed a moderate anemia, moderate leukocytosis, azotemia, acidosis and hypochloremia. The urine was heavily infected with *coli aerogenes*. Bilateral nephrostomy was done. On August 18, 1948 the PSP from the left kidney was 20 per cent at the end of two hours and 25 per cent at the end of five hours with no excretion from the right kidney and ureter in five



Fig. 9. A nephroureterogram reveals some improvement. The hydronephrosis is reduced when compared with Fig. 8. The ureter is straighter.

hours. The NPN and CO_2 were normal. On the same date each nephrostomy tube was injected with 20 per cent skiodan and x-ray studies revealed marked pyelectasis, calyctasis and ureterectasis bilaterally. In view of the non-functioning kidney on the right, right nephroureterectomy was performed on August 20, 1948. The pathologic diagnosis was congenital hypoplastic kidney and marked hypertrophy of the ureteralmuscularis. At the same time a urachal cyst was removed. The postoperative course was entirely benign. Laboratory studies remained within normal limits. Neurologic examination performed on this patient as well as the two preceding cases revealed no neurologic signs of myelodysplasia. The neurologist did not believe that the bladder difficulties were explained on a neurologic basis in any of the cases. On September 11, 1948 retrograde injection of contrast media through the left nephrostomy tube revealed ureteral dilatation, tortuosity and a marked hydronephrosis, Fig. 8. On September 22, 1948 the child was prepared for urethoplasty in a manner similar to the case previously described. The ureter was resected in such a way that 12 cm. of the redundant midportion was excised and the two ends reanastomosed in the usual fashion. The pathologic report on specimen of the ureter removed was "chronic ureteritis with hypertrophy of the musculature". The postoperative course was quite satisfactory. On October 3, 1948, the PSP from the remaining kidney was 40 per cent in two hours, but the NPN was 46 mg. per cent. The remaining chemical studies were normal. On October 18, 1948 a transurethral resection of the vesical neck was done. The pathologic diagnosis was chronic cystitis. The postoperative course and care of the various drains were similar to the previous cases. A rising NPN resulted in a second left nephrostomy on November 26, 1948. On December 28, 1948 a retrograde pyelogram through the nephrostomy tube revealed filling of the left ureter down to the pelvic brim and considerable resolution of the hydronephrotic process. The nephrostomy tube was removed. Follow-up studies demonstrated an incontinent patient whose blood



Fig. 10. R. B., Case 4. Retrograde pyelogram: Normal left kidney. Right ureteral angulation with dilatation and hydroureter.



Fig. 11. R. B., Case 4. Cystogram which shows right ureteral reflux but outlines a straightened, narrowed ureter, a dilated bladder and contrast media in the bowel has passed through the urethrocolic fistula.

chemistries were normal. Urologic studies revealed no residual urine. Ureteral reflux was present but the kidney and ureter were improved, Fig. 9.

Case 4. R. B., J.H.H. 435987. This patient was born with an imperforate anus. A colostomy was successfully performed 16 hours after birth. At the age of 2 months attempted perineal repair of the imperforate anus resulted in a rectourethral fistula. Intravenous pyelograms demonstrated ureterovesical obstruction,

right, with moderate hydronephrosis and hydroureter, right, with distortion of the ureter by a herniated loop of bowel, Fig. 10. Surgically, the ureter was mobilized transperitoneally and the lower half, 8 cm., was excised. The pathologic report was ureteral muscular hypertrophy and inflammation. It was then straightened, resected and closed over an 8F soft red rubber catheter. A neoureterostomy was performed. The ureterovesical obstruction was due to the dilated colon which had herniated through the posterior peritoneum. The original colostomy was revised. While the patient's preoperative blood chemistries were somewhat abnormal: NPN 41 mg. per cent and CO_2 16.6 meq/L, the postoperative chemistries on March 9, 1950 were normal. Fig. 11 shows the postoperative pyelogram which is interpreted to demonstrate some improvement over the preoperative x-rays.

Summary

Four cases of congenital urinary tract obstruction, three of which were associated with interesting extraurinary congenital anomalies, have been presented. Common to all four cases was dilatation and tortuosity of the ureter as well as hydronephrosis and dilated bladder. While in the past cystostomy had been the procedure of choice, reconstruction of the dilated tortuous ureter seemed indicated in view of the available surgical aids; i.e., antibiotics and synthetic materials. Following this premise, four patients were subjected to extensive ureteroplasty. The surgical technic employed is relatively simple and was discussed in detail. Preoperative and postoperative care was likewise discussed.

Conclusions

The dilated, redundant, tortuous, ureter, regardless of its cause, is in itself a definite obstruction to proper renal function. Satisfactory urinary drainage anywhere below the renal pelvis cannot occur in the presence of the dilated ureter. Ureteroplasty is indicated in those cases where sufficient renal reserve warrants extensive surgery. After adequate supportive measures and bilateral nephrostomy were performed, ureteroplasty and removal of the lower urinary tract obstruction followed. In this small series, in spite of the poor surgical risks, no surgical deaths were encountered.

The series is small but is offered as a stimulus for additional study on a group

of patients, who, in the past, had little chance of survival. No neurologic basis was found to explain these abnormalities.

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BLADDER DYSFUNCTION DUE TO CONGENITAL DEFECTS (BLADDER NECK OBSTRUCTION AND NEUROGENIC BLADDER) IN CHILDREN

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and

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Every physician who treats children or young people should be aware of the part congenital abnormalities can play in the cause of bladder dysfunction. Two such conditions, congenital bladder neck obstruction, which is mechanical; and neurogenic bladder due to defective innervation, are discussed together, because of the similarity in symptoms, age of patients, diagnostic approach, etc. *Being able to recognize the symptoms and signs of a bladder that fails to empty is the important thing that concerns the pediatrician and general practitioner*, differentiation of the two conditions can be left to the urologist, and may be difficult at times. Both lesions are somewhat rare; a pediatrician or general practitioner might see only a few such cases in a life time, but he can be of great service to these patients by recognizing the symptoms and making a diagnosis, as proper

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treatment must be started early in life if their kidney function is to be salvaged.

Difficulty in urination, involuntary loss of urine, or chronic or recurrent pyuria in a child should suggest the possibility of a congenital abnormality to his physician. Difficulty may be manifest by slowness in starting, poor caliber, or force of stream, or the child may have to strain to pass a few drops of urine. This may be due to increased resistance at the outlet of the bladder, resulting from a malformation causing a mechanical obstruction, or may be due to a weak detrusor urinae muscle resulting from defective innervation, which is unable to overcome the resistance at the bladder neck in a normal manner. Dribbling between, or instead of urination day or night, may result from a bladder that does not empty and is overflowing. The difference between the night wetting in these patients, and the functional bed wetter, is that the latter wets at intervals while these patients tend to drip constantly, or pass small amounts of urine frequently. Such patients are predisposed to chronic or recurrent attacks of pyuria because the bladder fails to empty retaining a pool of "stagnant" residual urine. Kidney damage is caused by back pressure, and is hastened if infection is superimposed. Children with chronic uremia, kidney infections, etc., are stunted in their development, malnutrition is prominent, and in extreme cases renal rickets may result in the patient being dwarfed.

Presented a patient with any of the above symptoms a physician can with a few simple diagnostic procedures make a screening examination. Immediately after the patient voids attempt to pass a catheter. If you are unable to pass a catheter of proper size into the bladder, or if more than a few cubic centimeters of residual urine are obtained, the patient should have special urologic studies. If facilities are available,



Fig. 1. Note Case report 2.

a non-protein nitrogen test, and x-rays of the kidneys, ureters, and bladder should be made. On the flat film defects in the sacrum should be looked for and tend to support the diagnosis of a neurogenic bladder. The renal function can be judged by the excretory urogram, providing the kidney is able to excrete the radiopaque contrast media. In cases of poor function delayed films may be helpful. A retrograde pyelogram should be made only when the information desired cannot be obtained by the intravenous method, and then one side at a time should be catheterized if the renal function is poor.

Treatment consists of surgical resection of the bladder neck to decrease its resistance to the flow of urine. This is best accomplished by the transurethral route, using a miniature electrotome which can be used in infants. The prognosis will depend on the degree of damage which has taken place

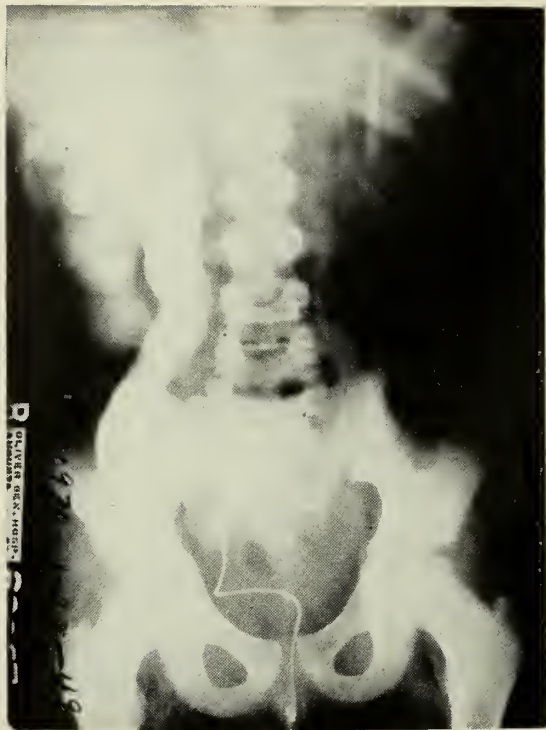


Fig. 2. Note Case report 3.

before treatment, but damage to the kidneys can be arrested in most cases.

REPORT OF CASES

Case 1 was a six weeks old male who had dribbled urine constantly, but never voided since birth. Kidney function was so poor that there was no diodrast excretion on excretory urogram; NPN 90 mg. Cystogram showed large cellules due to constant back pressure resulting from a congenital obstruction in the posterior urethra. Kidney function improved with suprapubic drainage, reducing the NPN to 28 mg., but the ureters were dilated and tortuous and seemed to be plastered down in their dilated state by periureteritis. Patient died 3 months later from pyelonephritis.

Case 2, Fig. 1. Retrograde pyelogram of right side in an 8 year old boy showing dilatation of the upper urinary tract. Residual urine 125 cc., NPN 72 mg., creatinine 3.4 mg., prior to surgery. Following resection of the bladder neck the residual urine was reduced to 15 cc., NPN 40 mg., and creatinine 1.9 mg. The kidneys made excellent improvement in fuction in this case.

Case 3, Fig. 2. Retrograde pyelogram on the right side in a 13 year old boy. Residual urine 40 oz., NPN 90 mg., carbon dioxide combining power 34 per cent. Following resection of the bladder neck the residual urine was reduced to 7 oz., and NPN mg. Over a period of time his residual urine reduced further to range between 3 oz. and $\frac{1}{2}$ oz. Considering the severity of this lesion improvement was excellent, but unfortunately too much damage had occurred before treatment was instituted. His growth has been stunted and his prognosis is not good.

Case 4, Fig. 3. An excretory urogram of a 3 year old boy showing dilatation of the upper urinary tract, and a defect in the sacrum supporting the opinion that the trouble is of neurogenic origin. History of recurrent bouts of urinary tract infection, and he had to strain to pass urine. Residual urine $1\frac{1}{2}$ oz., NPN

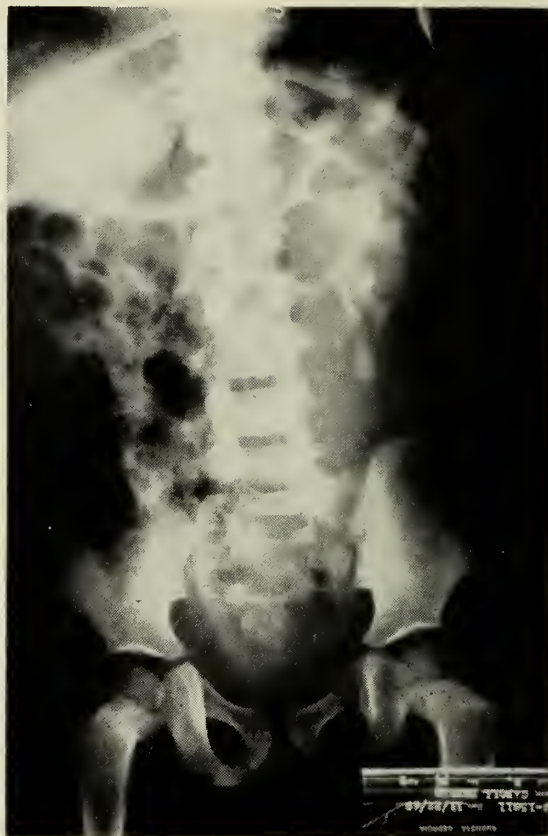


Fig. 3. Note Case report 4.

21 mg. Following resection of the bladder neck patient voids easily and residual urine ranges from none to 12 cc.

Case 5 was a man aged 28 years with the same type of lesion as case 4, who had been dribbling urine for 4 months and was found to have a residual urine of 700 cc. Excretory urogram shows dilatation of the upper urinary tract and a defect in the sacrum supports the diagnosis of a neurogenic bladder. Following resection of the bladder neck the patient voided normally and his residual urine was reduced to 50 cc.

Conclusion

Case reports have been presented which show the severe damage that takes place in the urinary tract when congenital malformations keep the bladder from emptying. Time is an important factor, as renal damage is progressive until proper treatment is instituted, and physicians should strive to recognize such cases early in life. Transurethral resection of the bladder neck is of proven value in cases of congenital bladder neck obstruction, and atonic bladder due to defective innervation.

THE USE OF RADIOACTIVE IODINE IN THE DIAGNOSIS AND TREATMENT OF DISEASES OF THE THYROID

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During recent years radioactive iodine has been used extensively in the study of thyroid physiology and the treatment of thyroid disease. Although radio-iodine did not become generally available until pile production was begun at Oak Ridge in 1946, the study of its medical applications was begun long before. The radioactive isotopes of iodine are among the oldest artificial elements, one of them having been produced by Fermi in 1934. They were introduced to medicine in 1938 when a short-lived isotope of iodine was first used in tracer studies of thyroid physiology¹. They have been used in the treatment of disease of the thyroid since 1941². There are several radioactive isotopes of iodine. The one in common use today is iodine 131 which gives off beta rays and gamma rays and has a half-life of eight days. The other available isotopes have a shorter half-life rendering them less useful.

There are four major applications of radio-iodine in medicine. It may be used as:

1. A tracer for the study of thyroid physiology.
2. A tracer for the diagnosis of hyperthyroidism.
3. A therapeutic agent for hyperthyroidism.
4. A therapeutic agent for cancer of the thyroid gland.

It will be noted that the first type of study

is most likely to increase our fundamental knowledge while the latter three applications are those which are of most interest to us clinically. I will confine my remarks to these clinical uses.

Use in Diagnosis

The use of radio-iodine as a tracer for diagnosis of the rate of thyroid activity depends upon the capacity of the thyroid gland to collect iodine and convert it into the thyroid hormone. The studies of many workers have proven that the percentage of an administered dose of radio-iodine which is taken up by the thyroid gland depends upon the relative activity of the gland³. Since the percentage of the administered dose which is collected by the thyroid can be measured with appropriate equipment, radio-iodine is a useful diagnostic tool in thyroid disease. We now know that iodine administered by mouth is almost totally absorbed. The amount picked up by the thyroid accounts for practically all that is retained in the body. Most of the remainder is excreted in the urine. The dose used for tracer work is small to avoid radiation hazard. We have used 50 microcurie doses given without any added inactive iodine. Several technics have been devised for measuring the uptake. When the tracer dose is administered, a duplicate sample is set aside to be used as a pilot for comparison to avoid any problem arising from the rate of decay. Its activity is measured at the same time as the activity from the patient's thyroid and the ratio of the two gives the per cent uptake. Figure 1 shows the Geiger counter assembly which we have used. The arrangement of four tubes eliminates any errors resulting from variation in the size and position of the thyroid gland. This figure shows the pilot sample in place for counting. Figure 2 shows the position occupied by a patient during counting. Measurements of uptake may be made at various

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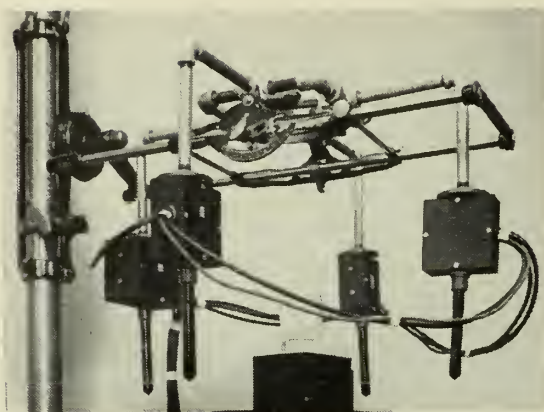


Fig. 1. Geiger counter assembly.



Fig. 2. Position occupied by a patient during counting

RADIO-IODINE UPTAKE IN HYPERTHYROIDISM (after Quimby et al.)

I 131 % uptake 24 hours	Euthyroid	Hyperthyroidism				
		Diffuse	Recurrent after I 131 after surgery		Nodular	Total
50 or more		48	9			57
HIGH 40 - 49	2	9	5	8	7	29
35 - 39	4	2	2	1		5
30 - 34	8	1		1		2
MEDIUM 20 - 29	24	1	1			2
10 - 19	18		2			2
LOW 0 - 9	1					
TOTAL	57	61	19	10	7	37

Table 1. Note text.

intervals. Some workers feel that it is more important to measure the rate at which the material is concentrated in the thyroid than the total amount deposited in the thyroid. It is simpler, however, to measure the total uptake alone. A maximum uptake is reached in twenty-four to forty-eight hours and the results of several groups using one or the other of these time intervals are approximately the same. We have made measurements at forty-eight hours in all patients studied. Comparison with measurements made at twenty-four hours in a few cases showed very little difference.

One of the most extensive studies of radio-iodine uptake in hyperthyroidism is that of Werner, Quimby and Schmidt⁴. Their results are summarized in Table 1 and demonstrates that 90 per cent of euthyroid individuals have an uptake of less than 35 per cent, whereas 94 per cent of hyperthyroid individuals have an uptake of more than 35 per cent. Two-thirds of those individuals with hyperthyroidism and a low uptake were instances of recurrent hyperthyroidism after treatment. The results of other workers are in agreement. Our own results in a small series are summarized

I 131 % uptake 48 hours	Hyperthyroidism			Euthyroid (anxiety state)	Hypothyroidism
	Diffuse	Nodular	Total		
50 or more	3	1	4		
HIGH 40 - 49	1		1		
35 - 39					
30 - 34					
MEDIUM 20 - 29	1	1	2	2	
10 - 19					1
LOW 0 - 9		1*	1		3
TOTAL	5	3	8	2	4

* toxic solitary adenoma

Table 2. Note text.

in Table 2 and are roughly similar. We believe that this method for the determination of thyroid activity is more accurate than the determination of the basal metabolic rate and approaches in accuracy the serum protein bound iodine determination.

Treatment of Thyrotoxicosis

Inasmuch as radio-iodine is concentrated in the thyroid and in the thyroid alone and is a source of radiation it offers an elegant means for selective radiation of the thyroid gland. The beta radiation is almost entirely absorbed within the gland itself. The gamma radiation is more penetrating and most of it escapes the body without being absorbed. Much higher amounts of radiation can be administered to the thyroid in this manner than would be possible by means of external radiation. For this reason radio-iodine has been used in the treatment of hyperthyroidism. A large number of patients have been treated in various clinics since 1941 and to date no fatalities nor any evidence of carcinogenic effects have been reported. Before discussing the relative merits of radio-iodine in the treat-

ment of hyperthyroidism, it would be well to mention the contraindications. They are as follows:

1. *Youth.* It is considered inadvisable to treat patients less than 45 years of age because of the possible late carcinogenic effects of radiation.

2. *Nodular goiters.* Not only is it a consensus that such goiters are best treated by surgery but it has been found that they necessitate large doses of radioactive iodine.

3. *Large goiters.* These are difficult to treat with radio-iodine primarily because they require large doses which increases the amount of radiation given to surrounding tissues. It is to be noted that all of these contraindications are based on fear of possible late ill effects from radiation which may be groundless.

The special indications for the use of radio-iodine in the treatment of hyperthyroidism are as follows:

1. Complications which make surgery risky.
2. Refusal of the patient to submit to surgery.

3. Thyrotoxicosis recurrent after surgery.

In addition to these indications there is also the possibility of elective use of radio-iodine in small diffuse goiters occurring in older people.

The advantages of radio-iodine therapy are:

1. *Ease of administration.* When proper apparatus and technical skill for the handling of radioactive isotopes are available, radio-iodine is easily administered and can be given to an ambulatory patient. It is much less expensive than surgery.

2. *The relative lack of toxicity.* The patient may develop a slight sore throat or there may be a mild exacerbation of the symptoms of thyrotoxicosis but these are transient and negligible symptoms. Death has been caused both by surgery and by anti-thyroid drugs. It has not been reported as the result of the therapeutic use of radio-iodine. Furthermore, there is no danger of hypo-parathyroidism, laryngeal paralysis, granulocytopenia, and other common complications of other means of therapy.

The disadvantages are definite. They are:

1. *The possibility of late effects of radiation as yet unknown.* It should be pointed out that for many years high intensity radiation has been administered to the thyroid gland in the treatment of hyperthyroidism by means of x-ray and there are no reports of untoward late effects.

2. *The slowness of response.* The radiation occurs over a prolonged period of time and the full effect is not reached for approximately two months, although when a good effect is obtained improvement will be noted in less than a month.

The correct dosage is not accurately known and our policy has been to give small doses repeating them at intervals of two months until a euthyroid condition has

been obtained. There is considerable danger in permitting a toxic patient to go very long without adequate treatment. We have attempted to overcome this disadvantage by the preliminary control of the patient with propylthiouracil. If this drug is stopped three days before administration of radio-iodine the uptake of the iodine will be adequate for therapy. The patient is then followed without further treatment of any kind in order to ascertain the effect of the radio-iodine. In the less toxic patients there is no need for the preliminary use of propylthiouracil.

We have, in general, used a dose of 4 millicuries of radio-iodine with subsequent doses varying from 2 to 6 millicuries as seemed indicated by the response to the first dose. Of the twenty-one patients we have treated, we have followed only fourteen for a period of at least three months. Eight of these have already exhibited a good result and two are considerably improved and still under treatment. Two others have shown some improvement and are continuing treatment. There have been only two failures both due to refusal to continue therapy. In the eight well-controlled patients the average total dose was 7.6 millicuries given in 2.4 doses. Only two have been controlled after a single dose. Full control has been accomplished in from two to twelve months with an average time of six months. There has been one recurrence now being retreated. There has been no hypothyroidism or other complications. The experience of others has indicated that at least 80 per cent of patients with hyperthyroidism can be completely controlled by the use of radio-iodine⁵. This includes many patients who could not be treated by any other means.

The last use of radio-iodine is in the treatment of cancer of the thyroid. It is to be considered only as a last resort in those

patients in whom surgery and x-ray therapy have failed. The effectiveness in cancer of the thyroid depends upon the ability of the abnormal thyroid tissue to function normally and take up the iodine. Since the tissue is abnormal, it is not to be expected to function very effectively and the more abnormal the histologic picture the less iodine is collected. About 15 per cent of thyroid cancers, however, may be expected to concentrate iodine making them possibilities for treatment in this fashion⁶. It has been found that if the normal thyroid tissue is removed surgically or destroyed by a preliminary dose of radioactivity, the uptake of iodine by the cancer tissue will be enhanced. Furthermore, it has been shown that by giving large doses of propylthiouracil there will be stimulation of some of the tumor tissue to function. By use of these means it is possible to make perhaps half of thyroid cancers take up radio-iodine in therapeutic amounts⁷. We have to date treated eight patients with cancer of the thyroid with radioactive iodine.⁸ We have obtained gratifying results in three of these. This may sound a pessimistic result. It must be remembered, however, that all of these patients were very ill with extensive metastases. The relief of the pain that has been seen in the three who responded well has been most gratifying.

Summary

In summary, then, radio-active iodine is a useful addition to our tools in the study and treatment of thyroid disease. It aids in the determination of the rate of thyroid activity and is effective in the treatment of toxic goiter. It also offers palliation in some cases of cancer of the thyroid gland.

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FOLIC ACID ANTAGONISTS IN THE TREATMENT OF ACUTE AND SUBACUTE LEUKEMIA

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The treatment of acute and subacute leukemia is, at best, still poor. Progress is being made, however, and we are able to effect in some cases complete remissions of varying duration with a new group of drugs known as folic acid antagonists.* Although "antagonists", they differ only slightly in structural formula from folic acid.

Franklin, Stokstad, and Jukes^{1,2} found that a folic acid antagonist, "x-methyl pteroyl glutamic acid," when fed to rats, mice, and chicks produced an acute deficiency syndrome which was reversed by increasing the dietary level of folic acid (pteroyl glutamic acid). They suggested that the preparation might be used to modify certain blood dyscrasias marked by leukocytosis because in rats the white count fell to exceedingly low levels. The synthesis of 4-amino pteroyl glutamic acid (aminopterin) was described by Seegers, Smith, and Hultquist.³ This compound was found to be the prototype of a new series of antagonists, which are characterized by high potency, marked clinical effects, toxicity, and limited or no reversibility by folic acid.

Farber and his co-workers began the use of certain of these compounds in the treat-

* A folic acid antagonist is a substance which possesses the property of inhibiting the growth of *Streptococcus Fecalis* R or L. Casei in the presence of marginal levels of folic acid.

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ment of acute leukemia in children⁴⁵⁶⁷. The first available compounds were pteroyl aspartic acid and methyl pteric acid, which they believed helped to prolong the lives of a few children. Beginning in November 1947, 4 amino pteroyl glutamic acid (aminopterin) became available, and the first impressive remissions in the course of acute leukemia were produced by the use of this drug.

The author's interest and experience in this problem began in 1948, when a research fellow with Dr. William Dameshek at the Blood Laboratory of the Pratt Diagnostic and the New England Center Hospitals. From April 1948 to June 1949 forty cases of acute and subacute leukemia were treated with one or more of the folic acid antagonists.* Of these forty cases, thirty-four were in adults and six in children. Eight patients died within one week and therefore cannot be considered as having received an adequate therapeutic trial of the drugs. Of the remaining thirty-two cases, twenty-seven were in adults and five in children. Ten of these developed remissions lasting for at least two months and averaging six to nine months. As of now (April 1950) two are still living and one has gone twenty-three months after onset of therapy. This is a remission rate of 31.3 per cent of those treated over one week's time and 25 per cent of all the cases. Best results were obtained in the lymphoblastic cases (six out of fourteen), and none of the four monocytic cases responded. A higher incidence of remissions occurred in the relatively slowly developing or subacute cases.

The folic acid antagonists used were: 4 amino pteroyl glutamic acid (aminop-

terin); 4 amino-9 methyl pteroyl glutamic acid (a-ninopterin), 4 amino, N¹⁰ methyl pteroyl glutamic acid (a-methopterin), and 4- amino pteroyl aspartic acid (amino-an-fol). Aminopterin and a-ninopterin have been used most extensively.

As to their relative effectiveness, aminopterin is given initially in a dosage of 1-4 mg. daily, a-ninopterin 5-25 mg. daily, a-methopterin 2-5 mg. daily, amino-an-fol 25-75 mg. daily, with the dosage varying according to the age and white blood count. For maintenance therapy, aminopterin 0.25 to 1 mg. daily, and a-ninopterin 5-10 mg. daily are used. Optimal maintenance doses of 0.5 mg. aminopterin daily for adults and 0.25 mg. daily for children have been worked out. Both aminopterin and a-ninopterin are given by mouth as well as by injection. Oral administration is as effective, mg. for mg., as the parenteral therapy. Scored tablets of aminopterin (1 mg.) and of a-ninopterin (5 mg.) are particularly useful for maintenance therapy.

These chemicals are injected intramuscularly or given orally daily until a toxic or pronounced hematologic reaction occurs as evidenced chiefly by a drop in the white cell count, following which the drug is discontinued. The time period and the dosage of drug given before discontinuance varies with each case. Usually the drug is discontinued after five days to three weeks upon the appearance of a toxic reaction. After the reaction subsides or the white count has become stabilized at a low level, the drug is resumed in a maintenance dose, usually orally. Maintenance therapy is continued except when a reaction takes place. If a relapse occurs, the therapeutic pattern is repeated: increasing the dosage of drug, awaiting a reaction or response, then returning to maintenance therapy. As most patients experience at least a mild toxic reaction, they do not feel subjectively im-

* Detailed data as regards these cases and results have been reported in a paper, "Folic Acid Antagonists in the Treatment of Acute and Subacute Leukemia", by Dameshek, W. L., Freedman, M. H., and Steinberg, L., *Blood*, in press, and in a monograph, *Chemotherapy of Leukemia and Leukosarcoma* by Dameshek, W. L., Bloom, M., Freedman, M. H., Weisfuse, L., and Leyrisse, M., published by Grune and Stratton, 1950.

proved until its subsidence. Objective clinical improvement such as regression of lymphadenopathy and of hepatosplenomegaly, is often noted within a few days after the beginning of treatment. Since an effective dose usually results in a "toxic" reaction, it is possible that a therapeutic dose may require the appearance of so-called toxic symptoms.

Toxic reactions usually appear between five days to three weeks after initiation of therapy, particularly with aminopterin. The first symptoms are sore mouth and throat, anorexia, and nausea; less frequently, vomiting and epigastric discomfort occur. Stomatitis and pharyngeal injection, especially of the peri-tonsillar pillars, are usually seen at this time together with occasional glossitis. The reaction may be progressive, especially if the drug is continued during the next several days when actual ulcerations of the buccal mucosa may be noted. Diarrhea with or without gastrointestinal hemorrhages may occasionally occur. A hemorrhagic rash and an apparent aggravation of the bleeding tendency often occurs. The effect of the drug is cumulative so that the best treatment is to discontinue it upon the first indication of any symptoms or sign of toxicity. Folic acid or liver extract are of no definite value in preventing or alleviating reaction.

Alopecia of varying degree is noted in patients who have been taking the drug regularly for one to two months, but regrowth of hair occurs even with continuation of therapy. After taking the drug for several months, generalized brownish pigmentation of the skin may appear which persists even though the drug is discontinued.

Clinical signs of a remission are disappearance of generalized malaise, fever, weakness, pallor, and hemorrhagic phenomena and regression of hepatosplenome-

galy and lymphadenopathy with the patient feeling and appearing markedly improved.

Hematologic indications of a remission are the development of a normal white count and differential and platelet count, a marked reduction of blast cells in the marrow with the appearance of megakaryocytes, mature granulocytes, and erythroblasts, and either an increase or maintenance of the red cell count in the peripheral blood without transfusion. The peripheral blood usually shows changes within a few days after treatment is instituted. The white count often drops rapidly from high to low levels within two to three days. If it is initially low, it usually decreases even further but the drop is by no means as rapid and spectacular. An initial normal or low white count is no contraindication to therapy. A rise in platelets, if initially low, is one of the best signs of a complete remission, and they are usually the last elements in the blood to respond.

A complete remission, if it occurs, usually becomes established two to four weeks after onset of treatment, frequently becoming apparent with subsidence of a toxic reaction and beginning of maintenance therapy. Improvement may, however, begin earlier. It is felt that continuous improvement should occur for at least two months before it is considered a definite remission.

All patients should receive fresh whole blood transfusions for control of hemorrhage and anemia and antibiotics for control of infection as indicated. There can be no doubt that this additional therapy plays an important role in contributing to a remission. The primary cause for the clinical and hematologic effects observed, however, must be ascribed to the use of the folic acid antagonists.

Adequate oral hygienic care, especially during the phase of reaction, is important. There is no need to mention the necessity

and beneficial effects of adequate nursing and psychologic care.

Discussion

It is evident that therapy with folic acid antagonists results in a much higher remission rate in acute and subacute leukemia than would be expected from the natural history of the disease or experienced with other forms of therapy. Certainly one cannot speak of any "cures." The duration of a remission is extremely variable. Although maintenance therapy is given, a relapse usually occurs which might not respond to increased dosage.

Considerable variation in results obtained with folic acid antagonists is reported by different investigators.⁸ Some observed practically no beneficial effects in any case; whereas others felt quite encouraged by the use of these drugs. Farber reported the largest series of cases, all in children, with remission occurring in approximately 68 per cent of fifty-nine patients treated over three weeks, the remissions being complete in 37.5 per cent of the cases^{8,9}. Our cases appeared to show the best remission rate in the reported cases in adults. It is possible that the variation in results is explained not only by the natural variability of acute leukemia from case to case, but by varying considerations as to what is constituted by a remission. Such factors as different methods of dosage patterns and the type of maintenance therapy employed by the various groups of workers might also be of distinct importance.

Summary

In summary, the folic acid antagonists (usually aminopterin) have, in varying degree, the capacity to induce remissions in about one-third of the cases of acute and subacute leukemia, in adults as well as children, and in both leukemic and leukopenic forms.

Clinical, hematologic and, to lesser ex-

tent, marrow remissions are obtained most commonly in the lymphoblastic type, least often in the monocytic type. The subacute cases respond far better than do those of the acute, fulminating variety.

Transfusions and antibiotics should be given as indicated. Thrombocytopenia and hemorrhage are difficult to control and frequently cause death before an adequate therapeutic trial of the drug can be given.

The exact mechanism of action of the folic acid antagonists is not known, but the observed remissions appear to be directly attributable to the action of the drug. Although temporary, they indicate that acute leukemia is not necessarily completely irreversible. Thus, there is hope that some more potent and less toxic factor may some day be discovered which will be of value in ultimate control of the disease.

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PULMONARY SARCOIDOSIS

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In 1889, Professor Boeck of Norway first described a peculiar type of skin nodule, calling it sarcoid because of the pos-

sible relationship to sarcoma. Besnier called the same skin nodules lupus pernio. In 1916, Shumann emphasized the histologic identity of the lesion, and described its widespread distribution. Hence the name sarcoid or Besnier-Boeck-Shumann disease.

The primary unit of sarcoid is the hard tubercle. This is about the size of the miliary tubercle in true tuberculosis. This unit is composed of a central giant cell surrounded by epithelioid cells and leukocytes. There is no caseation, calcification or surrounding inflammation as occurs in tuberculosis. The tubercle does undergo hyalinization and fibrosis. The lesion grows, not by increase in the size of the tubercle but rather by an increase in number. This process eventually replaces the lymphoid tissue. Most investigators believe the etiologic factor is not tuberculosis, although some consider sarcoid a bizarre form of tuberculosis.

Sarcoidosis usually has an insidious onset, runs a chronic, relapsing course, and shows mild constitutional symptoms. It is not a rare disease. It usually occurs between the ages of 20 and 30 years, but has been reported as early as two months and as late as 80 years. It may occur in any race, but is usually in Negroes. There is usually equal distribution between male and female. It is usually widespread anatomically, but may be limited to one system. There may be no symptoms, or there may be fever, fatigue, dyspnea, cough or weight loss. Peripheral lymph node enlargement is present at some stage in the disease in 90 per cent of the cases. Pulmonary involvement also occurs in 90 per cent of the cases. Skin and eye lesions are present in 40 per cent of the cases. Large spleen and liver are frequent findings.

Diagnosis is usually made by biopsy. If this is not obtainable, physical, x-ray and laboratory examinations may all be necessary for the diagnosis.

There is no specific treatment. Arsenic, gold, tuberculin, climatic, x-ray and other radiation may be helpful.

The disease runs a long course, showing periods of quiescence and relapse. Spontaneous recovery usually occurs, but one-fifth of the cases may be fatal. Tuberculosis is a frequent complication in the fatalities.

The lung pathologic changes are, as elsewhere, made up of the primary non-caseating, hard tubercle. The disease apparently begins in the interalveolar septa extending through the lymphatic structures of the parenchyma to the hilar lymph nodes. This predilection of sarcoid for the lymphatic structures of the parenchyma explains the diffuse streaking shown on the x-ray film. The early lung lesions are small and soft in appearance. Later the softness is replaced by a stringy and net-like fibrosis over the entire lung field. Fibrous tissue may ultimately replace this pulmonary lymphoid structure. The interalveolar pulmonary capillaries may be obliterated.

The lung changes are of three main types: 1. Hilar lymphadenopathy without demonstrable parenchymal disease; 2. Parenchymal disease without hilar lymphadenopathy, and 3. The usual type, a combination of the above showing both parenchymal and hilar lymphatic disease.

The parenchymal disease may be miliary, nodular or soft and patchy. These lesions average 3 mm. in diameter. The stages of the disease in the hilar and lung parenchyma do not necessarily correspond. There may be regression in one with progression in the other. Sixty per cent of all chest lesions will clear almost completely in two years. Following the disappearance of these lesions, recurrence in the lungs has been rare.

In the differential diagnosis, tuberculosis and Hodgkin's disease offer the greatest difficulty. Sarcoidosis may so closely resemble pulmonary tuberculosis that a diag-

nosis from a chest x-ray alone cannot be made. Fungus infection, carcinoma, pneumonia, periarteritis nodosa and chronic passive congestion also make the diagnosis difficult.

In conclusion, an apt description made by Doctor Carnes is worth remembering. "Sarcoidosis should be considered in the differential diagnosis of all cases of chronic, painless, lymphadenopathy, whether there are demonstrable lesions in the lungs or not. The diagnosis is not established by pathologic examination alone, but only in conjunction with the appropriate clinical and bacteriological evidence to eliminate other granulomatous infections."

DISCUSSIONS

DR. WALLACE L. BAZEMORE, (*Macon*): The paper of Dr. Scardino and his co-author emphasizes conservatism in the surgical correction of ureteral dilatation in children.

The term "ureteral obstruction" is used to embrace not only obstructive lesions occurring within the ureter but vesicle and bladder neck lesions likewise. Neglected disorders in either location present the dilated ureter they attempt to preserve. Obstructive anomalies within the ureter affect only the ureter and reno-pelvic architecture, while genital tract obstruction may result in dysfunction of the entire urinary system.

Non-obstructive ureteral dilatation may likewise attain enormous proportions, may present a thickened muscularis with little tortuosity or pyelectasia or a thin-walled, atonic ureter; the etiologic factor in the first being attributed to an embryologic development—the defect in the later to atony.

The essayists emphasize that removal of the obstructing lesion, if one exists, does not lend to correction of the tortuous hydroureter, that intractable upper tract infection usually persists in these cases after correction of bladder neck and urethral obstructions. They postulate that such a dilated ureter may act as a relative obstructor. On this basis, they justifiably employ ureteroplasty. Whereas the causative factor might be remediable in one condition and questionable or unknown in another, satisfactory, lasting results might not be uniformly constant.

The authors are commended on their approach to this entity. Should this approach lie in ureteroplasty alone or combined with surgery on the sympathetic system in non-obstructive hydroureter must be answered. An occasional case of non-obstructive megaloureter has been favorably influenced following lumbar sympathectomy. Reconstruction of the ureter with correction of the functional imbalance in non-obstructive ureterectasia has not been employed to my knowledge.

Many new surgical procedures are today attempted with every expectation of success while many problems previously requiring surgery are rarely encountered since the employment of sulfonamides and antibiotics. Their surgical correction of this obstructing, infected

reservoir, with excellent results obtained, will surely prompt its employment in future similar cases.

Dr. Rinker's paper emphasizes the necessity for early recognition and correction of vesicle and genital tract obstructions. Such obstructions may present from the external urinary meatus to the vesicle orifice. Phimosis, constricted meatus, stricture, diverticuli, valves, enlargement of the verumontanum or contracture and cyst of prostatic urethra may offend.

The symptoms that these children present may or may not be related to the urinary tract. Anemic in appearance, poor appetite, lethargy, frequent headaches or gastro-intestinal symptoms may predominate. Cytologic and chemical changes may be normal until infection changes the picture and attracts attention of the parent or physician.

A correct interpretation of these findings with appropriate measures for correction, as demonstrated by Dr. Rinker, is the only hope of preventing devastating sequela.

Correction may only require a meatotomy of a constricted meatus. This is probably the most frequent obstructive lesion we observe, not as devastating as others but just as sure to cause damage if permitted to exist over a long period. I plead for routine correction of the pin-point urinary meatus along with circumcision of infants.

The approach to the deeper obstructions may be transvesical, retropubic or transurethral. This approach should be deliberate by each operator, one which minimizes trauma and effectively relieves the existing obstruction.

DR. RUDOLPH BELL (*Thomasville*): Two very timely subjects have just been very ably presented to you; namely, "Early Management of Ureteral Obstruction in Children," by Dr. Scardino, and "Bladder Dysfunction in Children Due to Congenital Defects," by Dr. Rinker.

If but one thought is conveyed in the two messages, I should say let it be to remember that such conditions do occur in children and, if recognized in early life, can be corrected. It is a sad plight in medicine to see some of these individuals who have existed through ill health to maturity, and have the condition recognized after irreparable damage is done.

In urinary tract obstruction of long standing, pain ceases to be a significant factor. A stone completely blocking a ureter will produce kidney colic but after the blockage has remained for a period of time the pain subsides. However, the corresponding kidney is undergoing destruction. A similar picture may be noted in congenital obstruction to the urinary tract but the infant cannot explain the phenomena to his well wishers. As the obstruction becomes more prolonged the pain subsides, but the destruction to the kidney becomes more marked.

In children, urinary frequency, enuresis, pyuria and periodical attacks of fever are symptoms that cannot be ignored. Chemotherapy and antibiotics may afford some temporary relief but the symptoms will return. One is justified in giving palliative treatment one or two times in the presence of such symptoms, but if the symptoms return a third time a complete urologic investigation is mandatory.

In ureteral obstruction in children, ureteral stones, strictures, valves and extraureteral pressure produced by aberrant blood vessels or fibrous bands are also to be reckoned with.

Lantern slides: This is a case of complete destruction of a kidney in a three-year old child. The destruction was due to an aberrant blood vessel cording the ureter in its upper third.

Lantern slides: This second case is similar to the first except that the condition was corrected before

the kidney was destroyed. It was necessary to resect a portion of the ureter and anastomose it in this case.

Lantern slides: You can see the perfect result six months after operation.

I certainly enjoyed Dr. Scardino's and Dr. Rinker's presentations and Dr. Bazemore's discussion.

DR. HOLLOWAY BUSH (Macon): Dr. Huguley has presented a very complete paper on radio-active iodine in thyroid disease. We need a more accurate test for thyroid function, and radio-active iodine may prove to be of considerable value. The rate of absorption of the radio-active iodine is supposed to represent the thyroxine output of the gland. Information concerning the thyroxine output is helpful to the clinician but at least two disadvantages arise from this test. One is that there are wide gradations in thyroxine output in both normal and toxic thyroids, and there is no sharp line of separation between the two. While typical cases can be easily differentiated, many cases fall near the borderline where it is difficult to say whether they are very active normal or mildly hyperactive toxic thyroids. The second disadvantage is that patients vary in their reaction to thyroxine. One with moderate excess of thyroxine may have severe toxicity, while another with great excess of thyroxine may have only moderate toxicity. This means that we still have no absolute test for thyroid disease, and clinical evaluation must also be relied upon for proper diagnosis and treatment.

Dr. Freedman has made a very interesting presentation on folic acid antagonists in the treatment of acute and subacute leukemia. Of course, there is no cure for this dreadful disease. Remissions have been obtained with x-ray, nitrogen mustard, folic acid antagonists, and even with cortisone. However, there is a conservative minority in this field who believe it is dangerous to use any treatment in the acute cases which attacks the blood. This includes folic acid antagonists. They feel that the patient's life is in delicate balance and that the end is more often hastened rather than remission obtained.

I have no comment to make in regards to the excellent paper on pulmonary sarcoidosis.

In regards to syphilis, many of us were skeptical when penicillin was first brought out as a therapeutic agent in this condition. It seemed illogical that a drug that was so dramatic and fast acting should be effective in a disease in which treatment had been prolonged and difficult. Time has proven penicillin to be our most effective drug, particularly in early syphilis.

It is only natural that each new antibiotic since penicillin should also be tried in this condition.

While the usual accepted dosage for early syphilis is 5-6 million units, there has been considerable experimentation with much smaller doses. I shall close with this story. At a recent syphilology meeting four papers were given on early syphilis and each recommended a rather low dosage of penicillin. Later, each speaker was asked how much penicillin he would take if he contracted early syphilis. In every case the dose was much higher than the speaker had recommended in his paper.

DR. HENRY SCHMIDT (Augusta): One is definitely impressed by the lucid manner in which the papers have been presented this morning. I feel that the participants should all be highly commended for their splendid efforts.

What I am about to say by way of discussion certainly represents no accumulation of weighty thought and I assure you that my remarks are completely casual.

Concerning sarcoidosis, there is one fact that to me seems obvious and that is that few are concerned with its treatment. When speaking with various pathologists

about sarcoid one sometimes gets answers about tuberculosis, or about granuloma, or perhaps no answer at all. It might be wise to stress the importance of the biopsy in diagnosis. I feel that this is particularly true when the problem is one of Hodgkin's vs. sarcoid because of the widely variable prognoses. It is unfortunate that the skin test of the Scandinavian investigator Kveim produces such a prolonged and at times severe reaction; otherwise it might become quite helpful and popular after adequate study. One wonders why the blood calcium and phosphatase are regularly increased in this situation.

It is encouraging to note the persistence and zeal of hematologists in the treatment of leukemia with various substances. Each substance is tried with renewed hope. One constantly has to remember to remind the families of these unfortunate patients that trial and palliation are being attempted. This is true even of the newer substances such as ACTH and the newer procedures such as complete (or 95 per cent complete) blood replacement. In a very limited experience we have seen both of these given to patients whose fatal termination seemed near and who survived for an additional six months in the first instance, and in the second instance the patient is still with us for a shorter period. We have found it wise to remember the toxicity of the folic acid antagonists and particularly aminopterin.

My personal experience with I131 is nil, both from a standpoint of diagnosis and therapy. In trying to evaluate the results of others one feels that with tracer doses in the order of 10 Rutherford's or less, many formerly difficult diagnostic problems will be simplified. One cannot help being impressed by the difference in uptake between tracer and therapeutic doses which brings up, I believe, one of our chief difficulties in radioactive therapy and that is dosage. It is fairly simple to convert millicuries and microcuries to Rutherford's and viceversa; it is not too difficult to compute the specific activity of a sample for administration particularly since accurate standards are available, but when one begins to consider the RBE (relative biological effectiveness) and the REM (roentgen equivalent man) and the REP (roentgen equivalent physical) and RHM (roentgen per hour at one meter), the situation becomes very, very interesting if not difficult. It is felt that the future will clarify much concerning this. It is interesting to note that 24 and 48 hour readings are taken over the gland, particularly since the original work of Hamilton and Soley showed that the specific activity over the gland in hyperthyroid and euthyroid patients was practically the same after 48 hours, where as after 4-6 hours a marked difference existed. It seems paradoxical to use thiourea and RAI131 practically concurrently. Thiourea compounds and also the sulfonamides act chiefly by preventing iodine from becoming protein bound. In animals after therapeutic doses of thiourea the uptake averages 10 per cent, whereas in control animals uptake is of the order of 50 per cent. This is in contradistinction to the blockage seen in hypophysectomized animals where conversion of diiodotyrosine to thyroxine is greatly reduced. Perhaps it would be better to allow a two weeks' interval between the propylthiouracil and the I131, since it has been found experimentally that the therapeutic effect of the thiourea compounds is practically nil two weeks after the drug is discontinued. One feels that the effect of administered I131 would be enhanced with such a regimen. Even having such a limited experience with RA medication, I do not hesitate to minimize the dangers of late effects of I131 both locally and on the organism as a whole, locally because of the very adequate reason suggested by the author and on the organism as a whole because of the short half-life of the isotope being used.

Again allow me to commend the authors for their splendid presentations. Thank you.

VALUE OF THE CERVICAL SMEAR AS A ROUTINE OFFICE PROCEDURE

CHARLES G. BELLVILLE, M.D.
Bainbridge

Much impetus has been given to the early diagnosis of incipient cervical cancer since the revealing studies of Papanicolaou and Trout¹ in 1943. Yet, it remained for Pund² and others to demonstrate that carcinomas of the cervix uteri is apparently preceded by a neoplastic growth which remains in the non-invasive phase for an average of six to twelve years^{2,3}. It is the length of this interval which affords the practicing physician an opportunity for early cancer detection. It is now entirely within their scope to reduce the astounding and appalling 17,000 annual cancer deaths with 35 per cent comprising uterine cancer, of which 75 per cent is cancer of the cervix uteri^{4,7}.

Exfoliative cytologic studies have thus brought into the realm of the general practitioner an 80 per cent^{8,13} accurate method of early diagnosis of subclinical cancer of the cervix. A method so characteristically simple and easily performed, adds little time or effort to a routine office examination. He is also offered the strategic position of being the first professional contact and is therefore more apt to detect his share of the 2 per cent cancerous patients. Cave⁷ estimates that 14 per cent of the female office patients, who present themselves for their first office examination, have symptoms referable to the uterus of 3 months to 2 years in duration and impresses upon the physician the outcome of an incomplete office examination.

Much of this work has recently been diversified through the establishment of cancer screening centers thereby lightening the

load of the overworked but cooperative pathologist. Bishop⁸ believes that one pathologist and two technicians can only screen about 150 cases per week, thereby giving an idea of the magnitude of the problem of early cancer detection. The American Cancer Society⁹ recently stated that there are approximately 211 cancer detection centers in the United States with three being located in the State of Georgia; it is hoped that more exist at the present time.

Cytologic diagnosis is based upon the exfoliated cells from a cancerous area which retain the stigma of the disease. Increasing detection of preinvasive carcinoma of the cervix and uterus is due to a better understanding and establishment of the morphology of exfoliated cancer cells which Nieburgs¹⁰ designates as "Preinvasive cell groups". However, interpretation of pathologic findings must be taken with a word of caution since a negative report means that cancer cells are not found in the specimen and may lull both physician and patient into a false sense of security. Therefore, cytologic smears are intended only as a preliminary diagnostic step to be followed by a more extensive study of the cervical lesion by multiple cervical biopsies at the squamo-columnar junction and endocervical or endometrial curettment in order to arrive at a positive diagnosis. Nieburgs¹³ reports 80 per cent detection of asymptomatic preinvasive carcinoma by the cervical smear alone and 3.2 per cent positive cases by biopsy study in suspected cases. Emphasis on the accuracy of cervical smear method is further confirmed by Ayre¹⁴ and others to be from 5 to 7 per cent with about 4 to 6 per cent error; indeed, one of the most accurate methods presentable to the diagnostic armamentarium of the practitioner.

This improved diagnostic method for early detection of subclinical carcinoma of the cervix uteri now spotlights the most im-

From Bainbridge Hospital, Bainbridge, Ga. Received for publication Feb. 22, 1951.

portant disease of this organ. Detection is accurate both in the intact uterus and in the cervical stump in which Crawford¹² et al have reported 43 per cent occurrence of cancer. Methods of early diagnosis continue to improve yet little advance in treatment has been made within the past 15 to 20 years with the five-year survival rate of 15 to 25 per cent⁷ of this disease remaining approximately the same.

Results have been gratifying since the institution of the cervical smear as a routine office procedure; all female patients above the age of 19 years are now subjected to this procedure irrespective of chief complaint. Exfoliative cytologic examinations, or smears, have been done on 112* patients in whom two were positive for early subclinical preinvasive carcinoma; ten additional cases showed a nuclear change but inadequate for diagnosis and must therefore be repeated. This series does not include those cases in which the initial diagnosis of cancer of the cervix uteri was found by multiple biopsies of which we have had four within the past two years.

Clinically, symptoms appear of little value in detecting subclinical carcinoma; the infrequent complaint of "spotting" has not been a reliable criterion in our series although menorrhagia and metrorrhagia have been of more significance. We believe that those patients showing cervical lesions which have a 15 to 25 per cent⁹ predilection for cervical carcinoma (cervical erosion, cervicitis, leukoplakia, etc.) should have repeated cervical smears at frequent intervals regardless of disposition of these lesions. Each case should be individualized in regard to menstrual history which is characteristic of that patient and each deviation therefrom should be thoroughly investigated. Those patients of the pre- and post-menopausal periods should routinely

have smears especially following estrogenic therapy¹³, which Gusberg, Hoffman, Scheffy, and others believe results in atypical endometrial hyperplasia¹⁴, which is a prelude to "endometrial adenocarcinoma". These criteria for menopausal patients are also applicable to those who are receiving, or have received, irradiation therapy for menopausal bleeding. They have been found by Gladstone¹³ to develop corporal carcinoma four times as frequently as those who have not received such treatment. We believe that the cervical smear should be routine on all patients regardless of age, parity or menstrual history though we do believe those of the so-called "cancer families", and those who have had carcinoma elsewhere, should be most carefully appraised by frequent appointed office examinations inclusive of the cervical smear.

The following case first illustrates the ease with which an erroneous clinical diagnosis may result from a casual office examination and, second, the importance of clinical smears from innocuous cervixes:

Case 1. Mrs. E. W., aged 41, primigravida II, admitted to hospital Aug. 18, 1950 for pelvic operation. Smear taken on routine annual check-up one week prior to admission with cytologic diagnosis of "pre-invasive carcinoma with signs of invasiveness". History negative with exception of menopausal syndrome for three years, receiving oral and parenteral estrogens for "several months". Family history for cancer positive on paternal side with father having died with buccal carcinoma. Physical negative, inclusive of normal appearing cervix. Diagnosis confirmed by multiple cervical biopsies and endocervical curettment. Total hysterectomy on Aug. 21, 1950 with pathologic diagnosis of "squamous cell carcinoma grade I, with early invasion of the glandular structure". Postoperative course without complications, with dismissal on Aug. 31, 1950.

The second case may illustrate the need for meticulous investigation of all menstrual complaints which might be any deviation from that of the suspected normal cycle:

Case 2. Mrs. A. T. S., aged 43, primagravida I, admitted to the hospital Aug. 7, 1950 with chief complaint of irregular and excessive bleeding for the past 17 years. Present episode of five weeks duration with "off and on" bleeding during that period, with brownish discharge between flow. Family history negative for cancer; systematic reviews essentially negative. Speculum examination revealed moderate circumferen-

* Private files of Dr. H. A. Bridges and myself.

tial cervical erosion with some suggestive enlargement of the cervix. Cervical smear in July 1950 with diagnosis of "preinvasive carcinoma with signs of invasion". Biopsy and endocervical curettment confirmed the diagnosis: "Epidermoid carcinoma, grade II-III with early invasion of the cervical stroma". Total hysterectomy Aug. 14, 1950 with specimen confirming the above diagnosis. Postoperative convalescence normal, with dismissal Aug. 24, 1950.

In using exfoliative cytologic smears as an office screening procedure, specific recommendations are offered by Nieburgs¹⁰: (1) Patients are instructed to refrain from taking a douche prior to examination; (2) no lubricant is used during the examination or in preparation of the smear; (3) cotton applicators with six inch stem suffice and are preferred to other devices; (4) smear is made of the cervical mucus plug when and if present with second smear being taken within the os; (5) rotary movement of applicator is used to transfer material to slide; (6) slides are immersed immediately in fixing solution of equal parts of 95 per cent alcohol and ether for a minimal period of ten minutes, after which slides are removed and one to two drops of glycerine are placed on the slide containing the specimen and another clean slide sandwiched on top of this.

Once the diagnosis of "preinvasive carcinoma" is made, using this preliminary step of exfoliative cytologic studies, verification should be done by multiple cervical biopsies at the squamo-columnar junction and both endocervical and endometrial curettment. Value of the latter cannot be over-emphasized and is further substantiated by Pund and Echols¹⁵ who found endocervical curettment positive in 16 per cent of 9 cases having negative cervical biopsy. These multiple confirmatory steps in detection of early asymptomatic cervical carcinoma are important not only in differentiating preinvasive carcinoma from invasive carcinoma but also aids in determining surgical treatment and assessing irradiation therapy.

At present, we are somewhat radical in our surgical procedures. We are not en-

tirely in agreement with others in regard to disposition of the ovaries but extirpate these organs also unless diagnostic procedures have limited the carcinomatous area to the preinvasive stage; in patients over 35 years of age irradiation therapy is advised prophylactically even with minimal glandular and stromal involvement.

Conclusions

1. Cervical smears are readily adaptable as an office procedure in detection of incipient carcinoma of the cervix uteri and as a differentiating test between suspicious menopausal symptoms and malignant lesions.

2. The cost of cytologic smear test is a minor economic factor and obviates unnecessary expense of hospitalization and surgical procedures.

3. Exfoliative cytologic studies not only offer tangible evidence of asymptomatic carcinoma but are useful adjuncts in subsequent surgical procedures, and assessing irradiation therapy.

4. As a routine office procedure it is both efficacious and an efficient method in preventive oncology.

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Guests of Eli Lilly and Company

UNIVERSITY OF GEORGIA
SCHOOL OF MEDICINE
— AUGUSTA, GEORGIA —

MARCH 7, 8, AND 9, 1951

COMMUNICATION

Indianapolis 6, U.S.A., March 20, 1951

Edgar D. Shanks, M.D., Editor
Georgia State Medical Journal,
Doctors Building,
478 Peachtree St., N. E.,
Atlanta, Ga.

Dear Doctor Shanks:

We are attaching a photograph taken at the time the University of Georgia, School of Medicine were guests of Eli Lilly and Company on March 7, 8, and 9, 1951.

During their visit, they made a thorough inspection

of the Laboratories including the Research Laboratories, replica of the original laboratories, and the Biological Laboratories at Greenfield, Indiana, where demonstrations were made showing the production of biological products.

The thought occurs to us that you may wish to make use of this material as a news item in the Georgia State Medical Journal.

Very truly yours,

ELI LILLY AND COMPANY,
A. E. Stensby, *Manager*,
Professional Relations Department.

NOTICE

Beginning Monday, April 16, and continuing each Monday night through April, May, June and July, a series of lectures on psychiatry will be presented under the auspices of the Peachtree Sanitarium at 41 Peachtree Place, N. E. These lectures will constitute a review course in psychiatry, covering diagnosis of the various psychiatric diseases, plus the most recent forms of treatment. Social, nursing and medical problems in treatment will be discussed. Leading Atlanta psychiatrists, including Doctors Joseph Skobba, John D. Campbell, Joseph McElroy, Harry Lipton, Rives Chalmers, and Salmon A. Koff will present the lectures. All physicians in this area are invited to attend and bring your psychiatric problems for informal discussion to follow each lecture.

Time: each Monday evening at 8 p.m., beginning April 16th.

SEVENTH RURAL HEALTH CONFERENCE TO BE HELD IN DENVER IN 1952

Denver has been selected for the seventh annual National Conference on Rural Health, according to an announcement March 16 by Dr. F. S. Crockett of Lafayette, Ind., chairman of the American Medical Association's Committee on Rural Health.

The meeting will be held in the Shirley-Savoy Hotel, February 28, 29 and March 1, 1952, and will be sponsored by the committee in cooperation with leading farm organizations. The sixth annual meeting, held in Memphis, Tenn., recently, was attended by more than 600 medical, farm and agricultural extension leaders from all parts of the country.

Out of these conferences, Dr. Crockett pointed out, have developed programs for health improvement in small communities.

THE JOURNAL

OF THE
MEDICAL ASSOCIATION OF GEORGIA

EDCAR D. SHANKS, M.D., Editor
478 Peachtree Street, N. E., Atlanta, Ga.

APRIL, 1951

AUGUSTA SESSION, 1951

Augusta—Georgia's second oldest city and always noted for its hospitality—was host to the One Hundred First Annual Session of the Association, April 17-20. Despite claims made, and apologies offered, by members of Georgia's second oldest medical society—The Richmond County Medical Society—that the new H-bomb plant now being constructed near Augusta had transformed this old city into a modern metropolitan area, evidence was lacking to support any claim of a decline in the graciousness of its citizens. Indeed, a good time was experienced by all persons in attendance, whose thanks should go in large measure to the Committee on Arrangements of the Richmond County Medical Society.

The scientific program was replete with good material and was supported by excellent attendance at the scientific meetings. Three guest speakers added to the program. They were: Dr. Irving Wright, distinguished New York City cardiologist, who gave the Abner Wellborn Calhoun Lecture and whose subject was "Neuro-vascular Syndromes of the Shoulder Girdle. Including Hyperabduction Syndrome"; Dr. Curtice Rosser, distinguished Dallas, Texas, proctologist and currently President of the Southern Medical Association, whose subject was "The Evolution of a Specialty"; and Dr. George F. Lull, Chicago, distinguished former Army medical officer and now adding to his laurels as Secretary and General Manager of the American Medical Association, whose subject was "What American Doctors are Doing". Dr. Rosser's and General Lull's addresses were before a public meeting of the Association, as was that of our President, Dr. A. M. Phillips, Macon, whose subject was "The Physician's Responsibility". Dr. Phillips' address is published in this number of THE JOURNAL.

The House of Delegates held its regular meetings and attended to its usual business, as did the Council. Dues for 1952 were set at \$15. Usual appropriations were made to carry on the various activities of the Association. Perhaps one of the most important actions taken at this meeting was the adoption of a new Constitution

and By-Laws for the Association. This document will be published in full in a later number of this JOURNAL.

Registration for this session was as follows:

Total physicians (members 542, and visiting physicians 60)	602
Miscellaneous visitors	9
Exhibitors	73
	684
Woman's Auxiliary	195
Grand total	879

Next year's annual session will be held in Atlanta.

—E. D. S.

NEW OFFICERS OF THE ASSOCIATION

At the 101st annual session of the Association, held in Augusta April 17-20, new officers elected and installed were: Dr. W. F. Reavis, Waycross, President; Dr. C. F. Holton, Savannah, President-Elect; Dr. R. C. McGahee, Augusta, First Vice President; Dr. H. A. Seaman, Waycross, Second Vice President; Dr. David Henry Poer, Atlanta, Secretary-Treasurer; Dr. C. H. Richardson, Sr., Macon, Delegate to the American Medical Association; Dr. Bruce Schaefer, Toccoa, Councilor of the Ninth District, and Dr. H. L. Cheves, Union Point, Councilor of the Tenth District.

Naturally, the outgoing officers wish the incoming officers much success in the conduct of the affairs of the Association, which are becoming more complex each year. THE JOURNAL, speaking for the entire membership of the Association, extends its felicitations to the new officers and offers its cooperation to each of them in the work of organized medicine in the State of Georgia.

—E. D. S.

AWARD OF LOVING CUP

Dr. T. F. Abercrombie of Atlanta and Decatur, long time distinguished public health worker in Georgia and elsewhere, and for many years Director of the Georgia Department of Public Health, was the recipient of the Ware County Hookworm Loving Cup at the banquet of the Augusta session of the Association just ended. The award was made by Dr. C. H. Richardson, Sr., of Macon, Chairman of the Committee on Awards, who told of Dr. Abercrombie's excellent work in the early campaigns directed against hookworm infestation in the human, and of his continued interest in this and other phases of public health.

—E. D. S.



DAVID HENRY POER, M.D.,
Atlanta
Secretary-Treasurer

SCIENTIFIC EXHIBITS

Scientific exhibits at the Augusta session, 1951, were perhaps fewer in number than at some previous annual sessions, but their quality was of high standard. A committee of three physicians, whose names are never made known for obvious reasons, judged the exhibits with the following results:

First prize—Dr. J. Calvin Weaver, Atlanta. Exhibit: *Medical History*.

Second prize—Drs. N. Reeves, C. L. Leedham and V. P. Sydenstricker, Medical College of Georgia, Augusta. Exhibit: *Viral Hepatitis*.

Third prize—Drs. A. O. Parkes and Robert Greenblatt, Medical College of Georgia, Augusta. Exhibit: *Vulvar Luminescence*.

In addition, the following awards were made under Honorable Mention:

Dr. W. S. Flanagan, Medical College of Georgia. Exhibit: *Plastic Surgery*.

Drs. Nelson H. Brown, Sarah L. Clark, and M. L. Moss, Medical College of Georgia, Augusta. Exhibit: *Results of Prolonged ACTH Therapy (7,945 mg.) in a Patient with Pan-Hypopituitarism*.

—E. D. S.

EMERGENCY DOCTOR CALL SYSTEM HAS RAPID GROWTH

Medical societies in 329 communities have established night and emergency call systems, according to a report by the Board of Trustees of the American Medical Association. A survey made in the summer of 1948 had shown only 60 such plans in operation.

"While these plans vary greatly according to the size of the community, they all have the same purpose—to guarantee that the people of the community can obtain a doctor at any time of the day or night, any day in the year," it was stated by Dr. Louis H. Bauer of Hempstead, N. Y., chairman of the Board of Trustees.

"The systems are so efficient that even in New York County, which operates the largest emergency call system in the country, it requires no more than seven or eight minutes to have a doctor on his way to answer a call."

Dr. Bauer added that the board "urges all county medical societies that have not yet established a formal plan for answering night and emergency calls make that a completed project during the coming year."

USE CHLORAMPHENICOL TO TREAT INTESTINAL INFECTION

Chloramphenicol, an antibiotic, is being used with some success by two New York doctors in the management of Salmonella infection, an acute intestinal infection, according to an article in the March 17 *Journal of the American Medical Association*.

Drs. H. A. Weiner of Staten Island and John B. Liebler of Brooklyn report that although the antibiotic does not cure the infection, it does have a preventive or arresting effect on the growth of the bacteria, thus permitting the body to muster defenses against the infection.

The complex group of bacteria causing the infection are about 200 in number, the doctors said, pointing out that one or more types of Salmonella bacteria may be present in any one particular infection.

According to the article, all of the 200 different strains are potentially dangerous to both human beings and animals. Age, resistance of the patient and to some extent the specific strain of bacteria, explained the doctors, determine the nature of the individual infection.

Distribution of Salmonella infection is known to be world wide. Some persons, while not afflicted with acute manifestation of the disease, harbor the germs in their bodies and act as carriers or distributors of the infection, it was pointed out. In addition, over 40 animals, including fowl and lower mammals, have been found to carry the organisms. The doctors said the greatest reservoirs of infection in the United States are fowl and swine and that the bacteria have frequently been found in water, sewage, eggs, egg powder and a wide variety of food products.

Dr. Weiner and Dr. Liebler are both associated with the Halloran Veterans Administration Hospital.

PEPTIC ULCERS RELIEVED BY SEVERANCE OF NERVE

Surgical severance of the vagus nerve, which controls sensation and action in most of the abdominal organs, is an effective therapy for peptic ulcers which do not respond to medical treatment, according to two Chicago surgeons.

A peptic ulcer is seated on the mucous membrane of the stomach or duodenum, the first part of the small intestine, and is caused by the action of acid gastric juice. The condition has been attributed to nervous tensions.

Based on a seven-year study of the results of all vagotomies, as the operation is called, at the University of Chicago Clinics, Dr. Lester R. Dragsted and Dr. Edward R. Woodward concluded that "this is a relatively safe, efficient and practical method of surgical treatment." They reported their findings in the March 17 *Journal of the American Medical Association*.

Dr. Dragsted is head of the department of surgery in the University of Chicago School of Medicine. Dr. Woodward was formerly associated with the department but is now in the Army Medical Corps and is serving overseas.

In the period covered by their studies, vagotomies were performed on 509 patients. They reported:

"Four hundred and eight (80 per cent) of these patients are entirely well at the present time and are back at their usual occupations on unrestricted diets without any type of medication. Fifty-four (11 per cent) are apparently free of active ulcer disease but complain of some gastrointestinal symptoms, so that the results cannot be considered entirely satisfactory. Forty-seven (9 per cent) of the operations are considered failures."

To indicate the progress made in the technique, they analyzed the last 100 cases of the series, reporting good results in 87 per cent of the cases and fair results in 13 per cent. They added:

"There were no cases in which the ulcers failed to heal or symptomatic relief was not obtained and in which there were other disabling complications."

In some instances, vagotomy was performed in combination with gastroenterostomy, an operation which creates an artificial passage between the stomach and the intestines.

The beneficial effect of vagotomy is due to the decrease in gastric secretion produced by the elimination of the nervous phase of stimulation, it was pointed out. There is now satisfactory proof that patients with duodenal ulcers differ from normal persons in that they secrete an excessive amount of gastric juice in the fasting stomach between meals and as the result of the stimulus of food and other substances, they said.

"The healing of these ulcers following vagotomy supports the view that the excessively cor-

rosive properties of the gastric content are due to a hypersecretion of nervous origin," the doctors said.

RHEUMATIC FEVER KILLS MORE GIRLS THAN BOYS, STUDY REVEALS

The death rate for girls suffering from rheumatic fever and heart diseases is slightly higher than the mortality rate for boys, a recent study revealed.

The study, made by Dr. George Wolff of Washington, D. C., also disclosed the fact that death rates in the Middle Atlantic and Western Mountain regions average slightly higher than those in the rest of the country. A report of his findings is carried in the March 10 *Journal of the American Medical Association*.

For his survey, Dr. Wolff selected the period from 1939 through 1948 and divided the total number of children's deaths from rheumatic fever and heart ailments during that time into three age groups—5 through 9, 10 through 14, 15 through 19. Both white and non-white children are included.

Characterizing the age, race and sex differences in mortality revealed by the study he said:

"There was a distinct rise with age in mortality from rheumatic heart diseases in each succeeding age group from 5 to 19 years, for both races and both sexes. Death rates were consistently higher for non-white children than for white, a fact that suggests that a more unfavorable environment increases the risk of dying from rheumatic heart diseases. Finally, the death rates were somewhat higher among girls than boys. An exception was the much lower rate for white girls 15 through 19 years old, as compared with that for white boys, while non-white girls of this age had a markedly higher death rate than non-white boys."

The survey also showed that mortality among the nine geographic divisions of the country varied. "For both white and non-white children," the report said, "the death rates for acute rheumatic fever plus heart diseases are below average in the South, while in the Northeast, especially in the middle Atlantic division, they are significantly above average. In the Pacific division the death rates are as low as in the South and significantly below the country's average, while in the Mountain division they are exceptionally high for the white children in all age groups." (This bears out the frequent observation that in warmer climates rheumatic fever tends to be less prevalent and less severe.)

Although rheumatic fever and heart disease have advanced to a leading place among the killers of children, this advancement, Dr. Wolff points out, is not due to an increase in mortality from those diseases but to the decline in other childhood diseases.

Actually there is a distinct decrease in mor-

tality among white children over the past decades. He cited the 70 per cent decrease for the age groups 5 through 9 and 10 through 14 from 1919-21 to 1944 and 1945, and the 60 per cent decrease for the age group 15 through 19 years. The downward trend is continuing at the present. The average yearly death rate during a three-year period from 1939 to 1941 was 4.858 deaths. The number of deaths in 1948 was 2,515. These totals also include the under 5 years of age group.

The story, however, is "very different" for non-white children, he said. There is no consistent downward trend among them except in the age group 15 through 19 years. Even this decrease, he noted, is far behind that of the white adolescents in both sexes and amounts to hardly more than 25 per cent from 1919-21 to the report in 1944. Only in the last three years of the present survey was the decrease somewhat larger. According to Dr. Wolff, tuberculosis is still the greatest killer of non-white children.

DDT INSECTICIDE IS SAFE IF WISELY USED

DDT, an essentially poisonous material, can be used with a wide margin of safety if it is wisely used, reports the Committee on Pesticides of the Council on Pharmacy and Chemistry of the American Medical Association in the March 10 *Journal of the A.M.A.*

DDT—in the form of powders, solutions, emulsions and aerosols—has been widely used in recent years to control plant and animal pests as well as disease-carrying insects with a great deal of success.

The committee, which recently reviewed literature and case reports on the substance, points out that the poisonous effect of DDT on living organisms decreases with the increase in complexity of the organism. Thus insects, a lower type of organism, are destroyed by the substance while human beings and the higher types of animals are "not likely" to be harmed.

Some human deaths, however, have been caused by DDT and therefore "certain precautions must be observed to guard against its potential toxic properties," they added.

A warning was given to farmers to be careful when applying DDT to food or fodder crops. DDT applied directly to the edible portions of a plant may result in poisoning. It should not be used on dairy cattle or animals being prepared for slaughter, the committee pointed out, since there is a danger of accumulation of the substance in the milk and tissues of treated animals.

Other precautions suggested by the committee are as follows:

"DDT insecticides should never be stored in food cupboards or medicine chests where there is a likelihood of contamination of food or mistaken use. All exposed foods, utensils and working areas must be covered when kitchen

and dining areas are being sprayed. Children's toys or cribs and rooms occupied by sick people should not be sprayed. Use of oil solutions on household pets should be avoided and DDT powders should be used only where they cannot be licked off. Intimate skin contact with aerosol discharge is to be avoided. Plants and aquariums in the home should be removed or covered before applying DDT sprays or aerosols. The use of oil solutions in the vicinity of open fires should be avoided because of the inflammability of such mixtures. . . .

"Persons exposed to large amounts of DDT dusts and powders under confined conditions or where dust particles are not carried away by free movement of air currents should wear respirators. (Chronic poisoning from DDT may result from prolonged ingestion or exposure to small amounts). Such conditions might be encouraged in mass delousing procedures, larviciding with dusts, and manufacturing or formulating operations. Protective clothing should be worn when there is a possibility of greases and oils contaminating the skin, thereby enhancing the absorption of DDT dusts or powders. . . .

"Frequent or prolonged exposure to emulsions or solutions of DDT in petroleum oils and organic solvents should be avoided unless protective clothing, goggles and neoprene or solvent-resistant gloves are worn. (Oily solutions may be absorbed through the skin). Clothing must be changed promptly if concentrates are spilled on them. A contaminated skin area which has come in contact with DDT soaked clothing or spilled DDT concentrates should be washed immediately with soap and water. Concentrates should be mixed in well ventilated rooms and fire precaution observed when volatile and inflammable solvents are present. . . .

"Operators involved in large scale spraying or fogging with solutions of 5 per cent or more of DDT should wear respirators and other protective devices. Smoking is to be avoided during spraying when combustible mixtures are used. Greaseless skin lotions should be used on exposed body surfaces when irritant solvents are present in the formulation. Clothes should be changed and the body cleansed after each day's operation."

* * *

HEALTHGRAMS

Whatever we do to help the world, we have to start with health. There is not much that nations agree upon, but we can agree about health. Minnesota's Health, Dr. Knud Stowman, October, 1950.

* * *

Sixty to eighty million Americans, for one reason or another, annually consult a doctor, and it is known that the tuberculosis rate among them is much higher than among the general population. For this reason it is highly desirable that private physicians, including general practitioners, internists, and specialists, obtain a survey film of every patient who consults them unless the results of a recent chest x-ray survey are available. Pub. Health Rep., A. C. Christie, M.D., June 2, 1950.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

CHANGING EMPHASIS IN PUBLIC HEALTH

S. C. RUTLAND, M.D., *Director*
Local Health Organizations
Georgia Department of Public Health
Atlanta

The practice of public health has undergone change in recent years. Public health programs have expanded beyond activities concerned largely with environmental sanitation and now include all of the preventive medical sciences. A few years ago public health placed greater emphasis on the prevention of the acute communicable diseases and lesser emphasis on the prevention of the chronic diseases. Organized community thought and effort are now being directed to a greater degree toward the prevention of the consequences of the chronic diseases.

The change in community effort is reflected by the type bills introduced in the State Legislature. Examples are legislation dealing with cancer prevention and cure (Georgia Laws, 1937), crippled children (Georgia Laws, 1945), cerebral palsy (Georgia Laws, 1949), and occupational diseases (Georgia Laws, 1946). On the national level many bills have been introduced in the Congress. Among these are bills dealing with heart disease, cancer, mental hygiene, multiple sclerosis, blindness, venereal diseases, and others. This reversal of directed effort is largely due to the change which has occurred in the relative age distribution of the population.

The 1950 U. S. Census shows 11,500,000 persons to be 65 years or older, and it is predicted that by 1975 there will be 20,000,000 in this age group. In 1850, 17.8 per cent of our people were of age 45 or over, while in 1940, 26.5 per cent were 45 and over. On the other hand, in 1900, 44.4 per cent of the population was below 20 years of age, while in 1940 only 34.7 per cent were of comparable age.

In 1900 life expectancy at birth was 50 years, while today it is 67 years. This increase in the average duration of life is attributable almost entirely to a diminished infant mortality, and a successful campaign against certain diseases of infancy and early childhood. For persons of middle age and beyond, life expectancy has not increased to any great extent. In 1840 a man of age 50 could expect to live another 20 years, in 1920 he could expect another 21 years, while today he can expect to live a little more than 21 years.

With the shift that is occurring in the relative age distribution of the population, more persons are living to ages which show a relatively higher incidence of chronic disease. It

is estimated that 50 per cent of all people who reach the age of 50 will develop cardiac disease of some severity. Approximately one-half of all persons who reach the age of 70 may expect several years of semi- or full-invalidism before death.

Public health agencies recognize that the diagnosis of chronic diseases and treatment programs for chronic disease victims are predominately roles for the private practitioners of medicine. However, public health departments, voluntary health agencies, and social agencies must accept important roles in geriatric programs.

What is the role of official health agencies in the development of chronic disease programs? Some have questioned the effectiveness of preventive measures in this field. Nevertheless, the prevention of communicable diseases in early life, which is recognized as a public health activity, does prevent chronic illnesses in later life. Case finding programs in syphilis control, with early and adequate treatment by private physicians or at rapid treatment centers, do prevent the chronic disease manifestations of syphilitic heart disease or syphilis of the central nervous system. The prevention of diphtheria, scarlet fever, septic sore throat, typhoid fever and other infections does reduce the incidence of certain chronic diseases in later life.

The programs conducted by the Division of Industrial Hygiene of the Georgia Department of Public Health incorporate many measures designed to prevent chronic diseases. Large groups of our adult population are employed by business and industry. Skillfully and scientifically conducted surveys supervised by adequately trained public health consultants in industrial hygiene afford an opportunity to detect occupational hazards. The removal of the potential hazard or, in the event the hazard cannot be removed, the installation of protective devices or the inauguration of protective procedures may prevent silicosis, chronic bronchitis, chronic chemical poisoning, chronic dermatoses, occupational cancer, and other chronic diseases.

John J. Hanlon, Associate Professor of Public Health Practice, University of Michigan, states, "A complete program for chronic diseases should probably consist of seven parts: (1) research, (2) early diagnosis, (3) hospitalization and treatment, (4) follow-up, (5) rehabilitation, (6) education, and (7) custodial care. At the present time, continued and expanding research is still a fundamental necessity. In addition to the obvious need for the study of causes, diagnosis, and treatment of chronic diseases, research activities should include statistical studies of prevalence, incidence, and mortality in the various component groups of the

population, and administrative studies for the development of satisfactory and efficient methods of implementing a community program." Chronic disease research should include population sampling studies. Consanguineously related groups should be studied to determine familial tendencies toward certain chronic illnesses. Public or volunteer agencies may accept the responsibility.

Nutritional research and demonstrations carried out in institutions for the aged and chronically ill may properly be a program of the public health nutritionist.

The expansion of public health programs by most health departments has not reached the point to include all of the above mentioned parts. The tuberculosis control program, the cancer control program, and the syphilis control program of the Georgia Department of Public Health include more of the seven parts than the other programs. Other programs, such as nutrition and malaria control, include research, early diagnosis, follow-up and education. Programs involving the other more frequent chronic diseases; namely, rheumatism and arthritis, asthma, epilepsy, orthopedic impairments, hernia, bronchitis, varicose veins, vascular disease, and others have not been incorporated into public health as programs *per se*. Educational programs designed to promote and encourage periodic medical examinations have emphasized the disabling effects of the chronic diseases.

The most effective weapon in any program of disease control is early diagnosis. Public health educational programs urging people to take advantage of periodic physical examinations are universally conducted, yet many persons never, except when acutely ill, visit their family physician. In many cases the reasons for this are obvious. Public health departments can overcome a great degree of this lackadaisical attitude by conducting multiphase testing programs. X-ray, serologic tests, hemoglobin estimations, blood sugar determinations, and other public health services are accepted screening aids. These provide for referrals to private practitioners of medicine. This encourages early diagnosis.

In certain communities financially capable of expanding services, public health nursing may play a significant role in the care of the post-hospitalized chronic disease case. If the convalescent can be safely cared for at home it is economically sound to release the hospital bed for the more acutely ill. More often the chronic disease patient desires to be at home, and the majority of them can be cared for satisfactorily in their homes if home nursing is provided. The public health nurse can render valuable service in interpreting the physician's recommendations to the patient. Many chronically diseased individuals become maladjusted, and the understanding nurse may do much to allay

their fears, superstitions, and misunderstandings. Beyond this many need only the daily or less frequent bedside nursing visit.

Some persons suffer chronic diseases which are progressive and of long duration. Because no other facility is available, institutions providing custodial care for the aged are maintained by religious and other organizations. Some are operated privately as nursing homes. Regulations require that such homes providing nursing care in Georgia meet minimum standards of construction and repair, and that they provide for the safety and comfort of the patient and personnel. Legislative acts delegate to the State Department of Public Health the duty of enforcing these minimum requirements. More consideration should be given to the selection of sites for building such type facilities. If they could be located near general hospitals, medical care will be more available and could be provided by the residents of the hospital.

Programs dealing with chronic diseases and the problems of the aged are designed to provide "more years in life, more life in years." One of the most difficult situations facing the aged and chronically ill is the adjustment to unemployment and consequently reduced income. Prevention of the disabling effect of chronic illness assures the individual a longer period of productivity and income. Manpower is sorely needed, but more important is the sense of security and happiness that go with employment.

Public health departments are fully aware of the problems and difficulties encountered in the development of geriatric programs and further recognize that the programs call for collaboration and cooperation of public health agencies, volunteer health agencies, social agencies, and the medical and allied professions.

EATING FOR HEALTH

Food is essential to the human body to keep it functioning smoothly and an adequate supply, plus proper utilization by the body, frequently means good health as against nutritional ill health, according to a *Health Talk* issued by the Educational Committee of the Illinois State Medical Society.

A calorie is a measure of food energy. Carbohydrates are sugars, starches, celluloses and gums, for example, bread and potatoes. They provide energy. Proteins are made up of simpler nitrogen containing substances called amino acids. They provide energy and the material for growth and repair of tissues. One authority said if there were any one "secret of life", protein might be considered to be at the heart of it, since protein is the essential stuff of which all living tissue is made. About 18 per cent of the human body consists of protein. Hair, nails, skin and muscle tissue consist almost entirely of protein and water. Fats, made up of simpler material called fatty acids, provide energy, the reserves of the body, and are more slowly utilized.

While proteins can be a source of fuel for maintaining body temperature and for muscular work, fats and carbohydrates are the natural fuel foodstuffs.

To maintain an even balance, the body requires carbohydrates, fats, and proteins, plus certain minerals, vitamins and water. The intake of food can vary depending on occupation. For example, a worker in an office who does not have a great deal of exercise requires fewer calories than does the laborer or farmer whose daily activities demand more energy.

Nutrition experts agree that from 2,000 to 3,500 calories should be taken into the body each day to maintain a normal body balance as shown by a constant weight.

There are certain foods which have been designated "must" foods and which, if taken daily in adequate amounts, give the recommended number of calories to the human system, and also the minerals and vitamins, which, in minute amounts, are essential to proper use of foods in the body. These "must" foods are milk, eggs, meat, fruit, potatoes, vegetables, whole grain cereals and bread, and butter or reinforced margarine.

Today, Americans can be assured that eating sufficient amounts of the generous variety of foods available in this country will result in the body receiving the proper amounts of proteins, fats, carbohydrates, minerals and vitamins so necessary to tissue repair, the building of good bone structure, adequate energy for the day's tasks and general well-being.

It is only when the body shows a deficiency in these elements that the physician will prescribe supplementary minerals or vitamins. For example, a lack of iron in the system may result in anemia; inadequate calcium may contribute to tooth decay, while a deficiency of iodine may be a factor in certain forms of goiter.

It is wise to remember too that the end-result of a balanced diet is the ability and strength to perform well one's daily work.

Let your doctor give you a physical examination each year. He is the one to decide whether your body properly assimilates the food in your program of eating for health.

PHYSICIANS' ART SHOW AT AMERICAN MEDICAL ASSOCIATION MEETING ATLANTIC CITY

The American Physicians Art Association will have an art exhibit, as usual, during the A.M.A. convention at Atlantic City, N. J., June 11 to 15, 1951, inclusive. Any physician in the United States, Canada and Hawaii desiring to participate in this show should communicate with the secretary for particulars.

J. Henry Helser & Co., Inc., Investment Managers with offices on the Pacific Coast, are the new sponsors of the American Physicians Art Association and will award 200 trophies besides a special Helser Trophy—a large decorative cup depicting Yankee Ingenuity. This cup is to be awarded for art work done in any medium. Also the large Popularity Trophy will be awarded to the owner of the art piece receiving the most popular votes during the A.M.A. convention. Over 4000 members of the American Physicians Art Association will receive shortly, entry blanks, shipping labels and rules about this fourteenth art exhibition.

The Annual Art Banquet will be held Tuesday evening, June 12 at the Marlborough-Blenheim Hotel, Atlantic City, N. J.

F. H. REDEWILL, M.D., Secretary
American Physicians Art Association
760 Market St.,
San Francisco 2, Calif.

NEWS ITEMS

The Atlanta Area Chapter of the Georgia Heart Association met at the Academy of Medicine, Atlanta, on April 12. Program: "The Significance of a pulsating Sternoclavicular Joint in Dissecting Aneurysm," Dr. Clayton Sykes, Atlanta; "Vector Analysis of the EKG

in Myocardial Infarction," Dr. J. Willis Hurst, Atlanta. Dr. C. Purcell Roberts, Secretary-Treasurer.

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The Atlanta Radiological Society elected the following new officers at its March meeting: Dr. Albert Rayle, Sr., president; Dr. Leonard Long, vice-president; and Dr. J. Dudley King, secretary-treasurer.

* * *

Captain William G. Avery, former LaGrange physician, recently arrived in Tokyo. Captain Avery entered the Army Medical Corps in October, 1950.

* * *

The Bibb County Medical Society and its Auxiliary recently sponsored a public program at the First Baptist Church, Macon, featuring a talk on "Notions on Neurotics," by Dr. Hilton S. Reed of Atlantic City, N. J. The following seven doctors served as ushers: Drs. E. C. McMillan, J. B. Stewart, John I. Hall, Sam Patton, John Paul Jones, William Orr, and J. L. King, Jr.

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Dr. J. M. Byne, Jr., Waynesboro, was elected Chief of Staff of the new Burke County Hospital at a recent meeting of the medical staff. Other officers elected at the same time were Dr. Everett Barger, vice-president, and Dr. G. C. Green, secretary-treasurer. The active medical staff of the Burke County Hospital is composed of members of the Burke County Medical Society. They are as follows: Drs. Cleveland Thompson, Sr., Cleveland Thompson, Jr., D. L. Butterfield, H. F. Bent, W. C. McCarver, W. W. Hillis, and I. S. Lee.

* * *

The 1951 committees of the medical staff and the chiefs of service of the Warren A. Candler Hospital, Savannah, were recently announced by Dr. Thomas A. Peterson, chief of staff. They are as follows:

Committees of the medical staff include:

Executive committee: Dr. T. A. Peterson, chairman; Dr. Walter Brown, Dr. Henry Levington, Dr. Harold Smith, Dr. D. B. Fillingim.

Surgical committee: Dr. D. B. Fillingim, chairman; Dr. R. B. Gottschalk, Dr. John Zirkle.

Credentials committee: Dr. Walter Norton, chairman; Dr. John Elliott, Dr. John Stalvey.

Program committee: Dr. L. M. Freedman, chairman; Dr. L. K. Powers, Dr. Milton Mazo.

Records committee: Dr. Oscar Lott, chairman; Dr. C. R. A. Redmond, Dr. Charles E. Sax.

Fracture committee: Dr. Tayloe Compton, chairman; Dr. Walter Brown.

Anesthesia committee: Dr. W. L. Osteen, chairman; Dr. C. W. Westerfield.

Intern committee: Dr. John Elliott, chairman; Dr. E. T. Upson, Dr. Lee Howard, Jr.

Chiefs of service announced by Dr. Peterson are as follows:

Surgery: Dr. W. O. Bedingfield; internal medicine: Dr. Jules Victor, Jr.; pediatrics: Dr. R. L. Schley; ear, eye, nose and throat: Dr. George Faggart; genitourinary surgery: Dr. H. Y. Righton; dermatology: Dr. S. F. Rosen; obstetrics: Dr. Meyer Schneider; pathology: Dr. Lee Howard, Sr.; roentgenology: Dr. W. A. Cole; dental surgery: Dr. R. N. Kennedy.

* * *

Dr. Horace B. Cupp recently was named manager of the Lawson General Hospital, Chamblee. Dr. Cupp succeeds Dr. L. H. Hood who has been appointed manager of the VA Hospital at Richmond, Virginia.

* * *

Dr. Asa W. DeLoach, Savannah, recently announced the opening of a practice in general medicine and surgery in association with Dr. E. T. Upson, 201 East Hall Street, Savannah. Dr. DeLoach graduated from the University of Georgia School of Medicine, 1946, and interned at John Sealy Hospital, Galveston, Texas. He was a Fellow in Experimental Surgery at the University of Texas School of Medicine in 1947-48. Following this he served two years in the Medical Corps of

the U. S. Air Forces. He returned to the University of Texas for an additional training period in surgery before going to Savannah.

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Dr. Murdock Equen of the Ponce de Leon Eye and Ear Infirmary, Atlanta, announces the association of Dr. Frank W. Buckner, formerly of Albany, who will limit his practice to otolaryngology and bronchoscopy.

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The Fulton County Medical Society held its semi-monthly meeting on March 15 at the Academy of Medicine, Atlanta. Program: "Surgery of Lesions of the Face," by Dr. John R. Lewis, Jr.; Discussor, Dr. William G. Hamm; "The Creation of Atrial Septal Defects in the Dog—Physiological Observations and Attempts at Closure of Defects," by Dr. William B. Martin; Discussor, Dr. James V. Warren; Moderator, Dr. Duncan Shepard.

* * *

Dr. Harriet E. Gillette, Atlanta, recently spoke at the first annual meeting of the Savannah Cerebral Palsy Society held in the Wonderflame Room of the Savannah Gas Company. Dr. Gillette's lecture in 1949 inspired the civic movement which eventually led to the establishment of a school for cerebral palsied children in Savannah. She is at present medical director of the Aidmore Crippled Children's Convalescent Home and the Cerebral Palsy Day School of Atlanta as well as medical director of the Trustees' Garden Village School for Handicapped Children, Savannah.

* * *

Dr. Thomas F. Jackson, of Augusta, the Department of Radiology, Medical College of Georgia, is in Oak Ridge, Tennessee, studying techniques of using radioisotopes in research. He is one of 32 scientists enrolled in the 18th of a series of one-month courses in radioisotope techniques offered by the Oak Ridge Institute of Nuclear Studies. The institute, comprised of 26 Southern universities, conducts a broad program of research, training, and education in the nuclear sciences through a contract with the Atomic Energy Commission. Dr. Jackson plans to use radioisotopes in tracer and therapy studies.

* * *

Dr. Paul A. Keller, Athens, recently returned to his native city to open up a practice at 210 Hampton Court. Dr. Keller, a graduate of Emory University School of Medicine, served with the United States Medical Corps during the last war. He has had offices in Atlanta for the past 10 years, and has also had resident training on the medical staff of Lawson General Hospital, Chamblee.

* * *

Dr. William Henry Lippitt, Savannah, recently announced the opening of his office at 224½ East Huntingdon Street, Savannah, for the practice of general surgery. Dr. Lippitt graduated from the Johns Hopkins Medical School and interned at the Union Memorial Hospital, Baltimore. Following this he spent two years in the Armed Forces serving part of his duty at Fort Meade, Maryland. On returning to civilian life, Dr. Lippitt resumed his surgical training at the Lahey Clinic, Boston City Hospital, and New England Deaconess Hospital, all of Boston.

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Dr. Julian L. Lokey, formerly of Augusta, has been called into active service and is now Captain Julian L. Lokey, M.C., 0992177, United States Army Hospital, Fort Benning, Ga.

* * *

Dr. Sherwood C. Lynn, Savannah, recently reviewed the book "Korea Today" by George McCune at the Down Town branch of the Savannah Public Library. Dr. Lynn was selected to give the analysis of the book on Korea because of his first hand knowledge of the country, having been born there and having visited his native land in 1948. The book is regarded as one of

the most comprehensive volumes on the subject currently available and is recommended by the Savannah librarian to all who want to gain a background of what the whole problem is about.

* * *

Dr. Jay McLean, Savannah, has received wide publicity in the past few weeks concerning the use of heparin in the treatment of frostbitten limbs in Korea. Dr. McLean discovered heparin, an anticoagulant, in 1916 while doing research work at Johns Hopkins. The drug is credited with saving the frostbitten limbs of hundreds of Americans fighting in Korea.

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The Muscogee County Medical Society held its regular meeting on March 1 at the Columbus Country Club, Columbus. The principal speaker was Dr. Ralph A. Reis, a Chicago obstetrician, who is professor of obstetrics and gynecology at Northwestern University Medical School. Mr. Richard J. Eales, executive secretary of the public relations department of the Medical Association of Georgia, also spoke.

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Dr. A. M. Phillips, Macon, president of the Medical Association of Georgia, recently gave the address of welcome to the 11th annual Congress on Industrial Health in Atlanta.

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Dr. Norman P. Pursley, formerly of the Milledgeville State Hospital, Milledgeville, is now associated with the Georgia Training School for Mental Defectives, Gracewood.

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The Second District Medical Society held its meeting at the Elks Home, Moultrie on April 5. Program: "Common Skin Disease," by Dr. J. M. Bazemore, Augusta; "Indications for Surgery for Peptic Ulcer," by Dr. John W. McLeod, Moultrie; "The Problems of Chronic Recurrent Urticaria and Angioedema" by Dr. Mervin B. Wine, Thomasville; "Case Report: Bronchogenic Carcinoma in a Twelve Year Old" by Dr. Walter G. Thwaite, Quitman. The election of officers and a dinner were held after the program. The Woman's Auxiliary met in the Nurses Home of the Vereen Memorial Hospital, Moultrie.

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Dr. Horace D. Smith, formerly of the Veterans Administration Center, Los Angeles, California, is now with the Lawson VA Hospital, Chamblee. Dr. Smith is a member of the Bibb County Medical Society and the Medical Association of Georgia.

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Dr. Brooke F. Summerour, Dalton physician, announces that he is now 1st Lt. Brooke F. Summerour, M.C., Box 154, Station Hospital, Fort Benning, Ga.

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Dr. Edwin W. Turner, formerly of East Point, has recently been recalled to active duty with the U. S. Air Force. His new address is: Lt. Col. Edwin W. Turner, A0-422449, Second Medical Squadron, Hunter Air Force Base, Savannah.

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Drs. Edwin W. Turner and R. P. Tucker, of East Point, announce the removal of The Turner-Tucker Clinic to 115 Ware Avenue, East Point. General practice.

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The Veterans Administration Hospital, Lenwood, recently held a series of two lectures by Dr. C. P. Oberndorf, of New York City, on the "Development of Psychoanalysis in America." Dr. Oberndorf is a past president of the American Psychoanalytic Association and is a widely known author of numerous articles on psychiatry and psychoanalysis.

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Dr. R. W. Gerard, of the University of Chicago, recently gave a series of two lectures at the Veterans Administration Hospital, Lenwood, on the subject

"Physiologic Basis of Behavior." Dr. Gerard is a neurophysiologist who has done extensive and important research on the way in which nerves and the brain function. He has pioneered in the study of the effect of blood sugar on the brain and has investigated sleep and dreaming by means of brain waves.

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The Veterans Administration Hospital, Dublin, has announced the addition of Drs. Lillian Hadsell, William C. Becker, and Oscar M. Mims to the medical staff.

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Dr. Jules Victor, Jr., Savannah, recently addressed members of the Lions Club at the Hotel Savannah. Dr. Victor's stimulating talk prompted a collection among the members which netted the Heart Association \$52. He emphasized the importance of continued medical research in an effort to combat heart disease, a malady which took the lives of 12,000 Georgians in 1950.

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The Fulton County Medical Society held its semi-monthly meeting at the Academy of Medicine, Atlanta, on April 5. Dr. Charles C. Higgins, head of the Department of Urology, Cleveland Clinic, and a past president of the American Urological Association, delivered the Third Annual Ballenger Memorial Lecture on "Present Day Management of Renal Calculi." Dr. Harold P. McDonald, Atlanta, made the introduction.

* * *

Dr. W. Robert Dunn, formerly of Cumming, has been called into active service in the U. S. Navy Medical Corps and is now Lt. (jg) W. Robert Dunn, 495548, 508 Caroline Avenue, Isle of Palms, South Carolina.

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Dr. Frank K. Boland, Atlanta surgeon, recently gave a review of his book, "The First Anesthetic, The Story of Crawford Long" sponsored by the Fine Arts Committee of the Woman's Club, Dallas. Dr. and Mrs. Boland were honor guests at a dinner given by members of the executive board of the club. Quoting from *The Dallas New Era*: "This book written in a scientific and scholarly manner, tells the story of Dr. Crawford W. Long and presents evidence that Dr. Long performed the world's first operation under anesthesia at Jefferson, Georgia, March 30, 1842. This book is a valuable contribution to medical history and certainly to Georgia history. Georgians should be interested in securing for a native son the honor which belongs to him. Dr. Boland presented an autographed copy of his book to the Paulding County Library."

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Dr. James C. Metts, an internist of Savannah, addressed the medical staff and the members of the Laurens County Medical Society on the Post Graduate Lecture Series at the Veterans Administration Hospital, Dublin, on March 29. The subject of his address was "Diaphragmatic Hernia: Pathology and Diagnosis".

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Dr. David Henry Poer, Atlanta surgeon, and associate in surgery in the Emory University School of Medicine, recently spent some time in the Canal Zone on a teaching trip for the surgeon general of the U. S. Army.

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Dr. Claud P. Cobb, Jr., formerly of Douglasville, announces his association with the Turner-Tucker Clinic, 115 Ware Avenue, East Point.

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Dr. Ben Keith Looper, Canton, announces the opening of the Cherokee Clinic and Maternity Center, Brown and Main, Canton, for the general practice of medicine, surgery and obstetrics.

OBITUARY

Dr. John Turner McCall, Sr., prominent Rome physician, died in a Rome hospital, February 11, 1951, after a brief illness.

Dr. McCall was born in Cave Spring, Georgia, June 22, 1882, and was the son of the late Daniel Tucker McCall and Kate Turner McCall. He graduated from Atlanta College of Physicians and Surgeons, now Emory University School of Medicine, Atlanta, in 1904, and was in active practice up until the time of his last illness. He was the Chief of Staff of McCall Hospital and director of the Floyd County Cancer Clinic.

He was a member of the Floyd County Medical Society; Medical Association of Georgia; American Medical Association; American Hospital Association; a Fellow of the Southeastern Surgical Congress and a Fellow of the American College of Surgeons. He was also a member of the State Medical Advisory Committee with the Department of Education (Rehabilitation Division) and a director of the Georgia Tuberculosis Association.

He was active in civic and church circles, having been a past president of the Rome Rotary Club and a deacon of the First Baptist Church.

He is survived by his widow, Mrs. Bessie Kay McCall; one son, Dr. John Turner McCall, Jr., of Rome; a sister, Mrs. J. S. Daniel; two brothers, Dr. Mose T. McCall and W. C. McCall all of Rome.

Funeral services were conducted at the First Baptist Church in Rome, with the Rev. Forrest Lanier and Dr. Bunyan Stephens officiating. Interment was in the Myrtle Hill Cemetery, Rome.

* * *

Dr. William Maxey Etheridge, aged 78, retired general practitioner, Atlanta, died February 4, 1951. A resident of Atlanta for 45 years, Dr. Etheridge was born and reared in Thomaston. He graduated from the Atlanta School of Medicine, now Emory University School of Medicine, in 1908. Dr. Etheridge practiced in the Atlanta area for 40 years. He was interested in politics, and served on the City Council from 1918 to 1925. He was a member of Battle Hill Masonic Lodge and the English Avenue Methodist Church. Surviving are his wife, two daughters, Miss Mary Jean Etheridge and Mrs. George A. Stewart, and three brothers, all of Atlanta. Funeral services were held at the J. Austin Dillon Chapel, with the Rev. Franklin T. Puckett officiating. Burial was in West View Cemetery, Atlanta.

COUNTIES REPORTING FOR 1951

Baldwin County Medical Society

President—Wallace M. Gibson, Milledgeville
Vice-President—E. C. Leaphart, Milledgeville
Secretary-Treasurer—Robert D. Waller, Milledgeville
Delegate—Robert D. Waller, Milledgeville
Alternate Delegate—E. Y. Walker, Milledgeville
Censors—Y. H. Yarbrough, R. W. Bradford, and John D. Wiley, all of Milledgeville.

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Ben Hill County Medical Society

President—Roy Johnson, Jr., Fitzgerald
Vice-President—W. D. Willcox, Ocilla
Secretary-Treasurer—W. C. Sams, Jr., Ocilla
Delegate—G. W. Willis, Ocilla
Alternate Delegate—D. B. Ware, Fitzgerald

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Bibb County Medical Society

President—R. W. Edenfield, Macon
President-Elect—O. F. Keen, Macon
Vice-President—Ralph Newton, Macon
Secretary-Treasurer—Henry H. Tift, Macon
Delegates—J. B. Kay, Byron, and J. D. Applewhite, Macon
Alternate Delegates—E. C. McMillan and W. Earl Lewis, both of Macon.

Blue Ridge Medical Society

President—Courtney C. Brooks, Blue Ridge
 Vice-President—James F. O'Daniel, Ellijay
 Secretary-Treasurer—Thomas J. Hicks, McCaysville
 Delegate—James F. O'Daniel, Ellijay
 Alternate Delegate—Courtney C. Brooks, Blue Ridge

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**Georgia Medical Society
(Chatham County)**

President—L. B. Dunn, Savannah
 President-Elect—J. H. Pinholster, Savannah
 Vice-President—Sam Younghood, Jr., Savannah
 Secretary-Treasurer—Lawrence Lee, Jr., Savannah
 Delegates—John L. Elliott, Ralph O. Bowden, and
 Ruskin King, all of Savannah
 Alternate Delegates—Oscar H. Lott, Harold M. Smith,
 and Joseph Pacifici, all of Savannah

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Chattooga County Medical Society

President—William T. Gist, Summerville
 Secretary-Treasurer—William U. Hyden, Trion
 Delegate—John J. Allen, Trion

* * *

Cobb County Medical Society

President—E. A. Musarra, Marietta
 Vice-President—C. M. Garland, Jr., Smyrna
 Secretary-Treasurer—Bruce D. Burleigh, Marietta
 Delegate—W. H. Benson, Marietta
 Alternate Delegate—Luke G. Garrett, Jr., Austell

* * *

Coffee County Medical Society

President—H. G. Joiner, Douglas
 Vice-President—Dan A. Jardine, Douglas
 Secretary-Treasurer—Sage Harper, Douglas
 Delegate—L. H. Shellhouse, Willacoochee
 Censor—G. M. Ricketson, Douglas

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Colquitt County Medical Society

President—John F. McCoy, Moultrie
 Vice-President—J. B. Woodall, Moultrie
 Secretary-Treasurer—John F. McLeod, Moultrie
 Delegate—A. G. Funderburk, Moultrie
 Alternate Delegate—John W. McLeod, Moultrie
 Censors—J. R. Paulk, R. M. Joiner, and Frank M.
 Gay, all of Moultrie

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Columbia County Medical Society

Member—John G. Saggus, Harlem

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Dooly County Medical Society

President—O. K. Coleman, Vienna
 Secretary-Treasurer—Martin L. Malloy, Vienna
 Delegate—O. K. Coleman, Vienna
 Alternate Delegate—O. W. Kitchens, Byromville

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Floyd County Medical Society

President—Lee H. Battle, Jr., Rome
 Vice-President—Harry Dawson, Shannon
 Secretary-Treasurer—Russell E. Andrews, Jr., Rome
 Delegate—Warren Gilbert, Rome
 Alternate Delegate—Oliver W. Jenkins, Lindale

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Gordon County Medical Society

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 Vice-President—Byron H. Steele, Fairmount
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 Delegate—W. D. Hall, Calhoun
 Alternate Delegate—J. E. Billings, Calhoun

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Greene County Medical Society

President—F. H. Killam, Greensboro

* * *

Hancock County Medical Society

President—H. L. Earl, Sparta
 Vice-President—L. P. Elam, Sparta
 Secretary-Treasurer—George M. Lane
 Delegate—C. S. Jernigan, Sparta

Hart County Medical Society

President—George T. Harper, Dewy Rose
 Secretary-Treasurer—Louis G. Cacchioli, Hartwell
 Delegate—J. Hubert Milford, Hartwell

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Henry County Medical Society

President—H. C. Ellis, McDonough
 Secretary-Treasurer—G. R. Foster, Jr., McDonough
 Delegate—R. V. Brandon, McDonough

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Jefferson County Medical Society

President—John R. Lewis, Louisville
 Secretary-Treasurer—James W. Pilcher, Louisville
 Delegate—C. Roy Williams, Wadley
 Alternate Delegate—Walter J. Revell, Louisville

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Lamar County Medical Society

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 Vice-President—John B. Crawford, Barnesville
 Secretary-Treasurer—S. B. Traylor, Barnesville
 Delegate—J. A. Corry, Barnesville
 Alternate Delegate—D. W. Pritchett, Barnesville

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 Vice-President—Charles A. Hodges, Duhlin
 Secretary-Treasurer—O. H. Cheek, Duhlin
 Delegate—John A. Bell, Jr., Duhlin
 Censors—A. T. Coleman, A. T. Moye, Duhlin, and Wm.
 A. Dodd, Wrightsville

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Montgomery County Medical Society

President—W. M. Moses, Uvalda
 Secretary-Treasurer—J. W. Palmer, Ailey
 Delegate—J. W. Palmer, Ailey

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Ocmulgee County Medical Society

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 Vice-President—W. R. Baker, Hawkinsville
 Secretary-Treasurer—James L. Thomson, Eastman
 Delegate—Albert R. Bush, Hawkinsville
 Alternate Delegate—Richard L. Smith, Cochran

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**South Georgia Medical Society
(Berrien-Clutch-Cook-Echols-Lanier
and Lowndes Counties)**

President—E. Harry Mixson, Valdosta
 Vice-President—Joyce F. Mixson, Jr., Valdosta
 Secretary-Treasurer—Alexander G. Little, Jr., Valdosta
 Delegate—Alexander G. Little, Jr., Valdosta
 Alternate Delegate—Fred N. Clements, Adel
 Censors—Robert E. Perry, Jr., Valdosta; James S.
 Peters, Jr., Nashville, and Jesse Parrott, Hahira

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Stephens County Medical Society

President—Robert E. Shiflet, Toccoa
 Vice-President—E. F. Chaffin, Toccoa
 Secretary-Treasurer—C. L. Ayers, Toccoa
 Delegate—Arthur G. Singer, Toccoa
 Alternate Delegate—Robert E. Shiflet, Toccoa
 Censors—Robert E. Shiflet, H. H. McNeely, and Parish
 B. Cleveland, all of Toccoa

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Taylor County Medical Society

President—Lewis Beason, Butler
 Vice-President—F. H. Sams, Reynolds
 Secretary-Treasurer—E. C. Whatley, Reynolds
 Delegate—R. C. Montgomery, Butler
 Censors—F. H. Sams, Reynolds, and R. C. Montgomery,
 II, Butler

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Thomas County Medical Society

President—Marion A. Baldwin, Thomasville
 Vice-President—Fred E. Murphy, Jr., Thomasville
 Secretary-Treasurer—Kirk Shepard, Thomasville
 Delegate—George R. Dillinger, Thomasville

Alternate Delegate—Howard L. Cheshire, Thomasville
 Censors—C. H. Watts, H. M. Moore, and John W. Mobley, all of Thomasville
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Toombs County Medical Society

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 Secretary-Treasurer—R. H. DeJarnette, Vidalia
 Delegate—J. E. Mercer, Vidalia
 Alternate Delegate—R. H. DeJarnette, Vidalia
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Troup County Medical Society

President—Willis M. Hendricks, LaGrange
 Secretary-Treasurer—William B. Fackler, Jr., LaGrange
 Delegate—J. S. Holder, LaGrange
 Alternate Delegate—Charles T. Cowart, LaGrange
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Upson County Medical Society

President—Douglas L. Head, Jr., Thomaston
 Vice-President—Robert L. Carter, Thomaston
 Secretary-Treasurer—James A. Woodall, Thomaston
 Delegate—John D. Blackburn, Thomaston
 Alternate Delegate—John E. Garner, Thomaston
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Walker-Catoosa-Dade Medical Society

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 Vice-President—Roy Pope, Jr., Chickamauga
 Secretary-Treasurer—Thos. W. Alsobrook, Rossville
 Delegate—Howard C. Derrick, Jr., LaFayette
 Alternate Delegate—S. B. Kitchens, LaFayette
 Censors—Fred H. Simminton, Chickamauga; S. B. Kitchens, LaFayette, and Chas. W. Stephenson, Ringgold.
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Washington County Medical Society

President—Joseph E. Lever, Sandersville
 Vice-President—N. Overby, Sandersville
 Secretary-Treasurer—Farris T. McElreath, Jr., Tennille
 Delegate—Emory G. Newsome, Sandersville
 Alternate Delegate—B. L. Helton, Sandersville
 Censors—B. L. Helton, N. Overby, both of Sandersville, and R. E. Taylor, Dabivboro
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Wayne County Medical Society

President—James W. Yeomans, Jesup
 Vice-President—J. A. Leapheart, Jesup
 Secretary-Treasurer—Fred M. Harper, Jesup
 Delegate—Robert A. Pumpelly, Jesup
 Alternate Delegate—Fred M. Harper, Jesup
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Worth County Medical Society

President—J. L. Tracy, Jr., Sylvester
 Secretary-Treasurer—H. G. Davis, Jr., Sylvester
 Delegate—W. P. Stoner, Sylvester

WHAT IS CHRONIC ILLNESS?

Any condition that keeps the patient sick or inactive for a long period of time is considered chronic illness. The fact that the group of diseases falling into the category of chronic illness is growing larger all the time is reflected in the advances of medicine which have reduced the acute illness to a short period of recovery. If we are going to live longer, the changing processes of the body in the older years will bring about chronic illness, the Educational Committee of the Illinois State Medical Society explains in a *Health Talk*.

While certain conditions provoke a chronic illness in the older age group, there are some that affect young adults and even children. Among these are rheumatic fever, tuberculosis, and some blood diseases such as leukemia. Fully one half of the chronically ill are below the ages of forty-five and 16 per cent are below twenty-five.

Among the conditions requiring prolonged care are certain types of heart disease, including arteriosclerosis; cerebral vascular accidents or the so-called "stroke" or apoplexy; arthritis; various forms of paralysis, in-

cluding other chronic disabilities resulting from disease or accident.

The care of the old and the person with chronic illness is necessarily a community problem which calls for understanding. No one who has worked to maintain himself can easily settle down to inactivity and dependence on another. And that is why there are three important aspects in chronic illness: prevention, care of the chronically ill patient and rehabilitation.

Prevention can be achieved in some measure by educating the young to an adequate knowledge of good nutrition, since this is one of the most important fundamentals in good health. The periodic physical examination is another basic step. Cancer and tuberculosis are notable examples, for if these conditions are detected early, recovery is assured.

Whether cared for in the home, hospital or nursing home, the chronically ill patient requires special attention. Long hours of bed rest can result in bed sores which are most uncomfortable. Turning the patient carefully at different intervals will obviate the development of this condition. Clean linens, a bright tray and a cheerful smile will do much to keep the patient in good spirits. The person caring for the patient should have the ability to convey understanding so that the patient's mind will be free of worry that he is a burden.

A person with chronic illness should be inspired to new interests or resuming old ones. Any hobby, whether it is making doll clothes or whittling boats can be stimulating. It is the mental stimulus that counts, as well as the graded physical activity of bringing muscles into play.

While it is true that many chronically ill patients, especially those with fatal and malignant disease, or with permanent derangements of the brain, cannot be restored to complete usefulness, the majority of them can be given new hope, new life, and a new and rightful place in the community.

SAYS DOCTOR GETS "RAW DEAL" AT INCOME TAX-PAYING TIME

With the income tax deadline just passed, you can take it from an economist that the average physician gets a "raw deal" on his income tax rate.

And, in the words of Frank G. Dickinson, director of the Bureau of Medical Economic Research of the American Medical Association, here is why:

"Most of us employed by companies are covered by pension or profit-sharing plans chalked up to 'operating expenses.' We are not taxed for these extra earnings until we receive them. By then, most of us are retired and our tax burdens are reduced because we are in the lower income tax brackets. Among physicians and other professional workers, only those employed by companies are eligible for such pensions. Most professional persons are self-employed; they cannot charge off a pension to business expenses.

"The physician has the longest training period among professional people, starting to earn around age 28. During his nine or more years of training, his lost income and expenses amount to about \$35,000. Accordingly, he must earn \$5,000 extra each year in order to catch up to the person who went to work at 18. His lifetime earnings are bunched into relatively few peak-earning years. During these years he is in a higher income tax bracket.

"Over a lifetime, then, he pays more taxes than a man who earns the same amount over a longer period, and he cannot finance any part of a pension out of tax-free business expenses."

COMMONWEALTH FUND GIVES \$60,000 FOR STUDY OF PREVALENCE OF CHRONIC DISEASE

To find out how many people in the United States are chronically ill and what facilities and services they need, a special study of chronic disease prevalence will

be launched, it was announced recently by Morton L. Levin, M.D., director of the national Commission on Chronic Illness.

A grant of \$60,000 has been made by the Commonwealth Fund to the Hunterdon County ((New Jersey) Medical Center for a study of the incidence of disabling chronic illness in the rural population, he said.

The study will be based on plans developed by the Commission on Chronic Illness and will be carried out by the Hunterdon Medical Center under the direction of Ray E. Trussell, M.D., Medical Center director, with consultation from the commission staff.

Every community in the United States recognizes the need for more facilities for care of the growing numbers of chronically ill people. No one knows the number of people and the extent of their need for more services.

The two studies of incidence of long term disabling illness, one in the rural community and another among city dwellers, should provide yardsticks or develop methods for determining them. Individual communities would then be able to measure their own needs for more hospital beds, home care programs, rehabilitation and other community services for the chronically ill.

WHY BE FAT?

Obesity is actually a disease characterized by an abnormal appetite. Seldom, if ever, is it due primarily to serious glandular disease. This is a popular misconception behind which many obese individuals seek refuge, the Educational Committee of the Illinois State Medical Society observes in a *Health Talk*.

Many constitutional diseases may frequently be avoided by proper nutrition and care in the selection of foods, since the maintenance of good health is dependent in a large measure on the food we eat. One of the most common dietary disturbances is obesity.

Excessive intake of food leads to the accumulation of abnormal amounts of body fat. Some people eat excessively during periods of stress and tension. Others eat just because they like to eat. Overweight is simply due to over-eating. In certain glandular diseases, such as hypothyroidism where the thyroid is sluggish, the need for food is less than normal. Even individuals with this condition eat more food than is actually needed. The activity of the gland can be corrected with certain medications, but the fat must be lost by strict adherence to a lowered caloric intake. Relatively few obese individuals suffer from hypothyroidism.

By far the majority of those who are overweight simply take in more food than is necessary to supply the daily energy required. The portion of food over and above the daily needs is stored in the fat depots. The sites of the greatest fat storage are in the shoulders, abdomen and hips.

Many diet fads make their appearance from time to time and gain undeserved popularity. Some of these are nutritionally inadequate and unbalanced and lead to acute deficiency states and lowering of general bodily resistance. Ideally a reduction diet should be a balanced diet and should be under a physician's supervision to safeguard one's health. A sane and sensible reduction diet consists of 1000 to 1200 calories properly balanced to contain a relatively high amount of protein, a moderate amount of carbohydrate and a low content of fat.

Fat is the least vital of the basic food requirements, although a minimum should be present in the diet to insure the adequate absorption of the fat soluble vitamins.

Carbohydrates, such as the sugars and starches, are the main source of energy supply in the reduction program, while proteins supply the needed building for tissue replacement and repair because of the natural wear and tear and breakdown of tissues which occur daily.

Obese individuals are much more prone to certain constitutional diseases, such as high blood pressure, accelerated hardening of the arteries and diabetes. Excessive weight may lead to an increased load on the heart as well as on all vital organs in the body.

With these points in mind, everyone should guard against overweight. Active industrial workers require more food intake to keep their strength and energy at a normal level, and those engaged in sedentary or desk work require less.

So why be fat? Maintain your food requirements at a level to maintain good general health, thereby reducing your chances to develop the diseases associated with obesity.

CONGENITAL CLUB FEET

When a child is born with club feet, parents are often-times the target of suspicious and unkind remarks. This is unfair and denotes ignorance and lack of knowledge, the Educational Committee of the Illinois State Medical Society observes in a *Health Talk*.

A congenital deformity is one which is acquired by the individual before birth. While it is true that, in some rare instances, heredity may be a factor, congenital defects, of which club feet is one, are usually attributed to improper development during the prenatal period. This is a condition over which the parents have no control. Because of this, they should certainly not be censured.

A common congenital club foot is one where the foot is turned inward so that the sole is pointing backwards and the inner side of the foot is pointing upward. Generally, correction is started in the first year of life so that the child will have a straight foot and ankle when he is ready to begin weight bearing.

While surgery is frequently indicated, it is not always necessary, since some cases respond to what is called over-correction. When this procedure is used, the foot is placed in an over-corrected position by application of a cast. Subsequent technics to keep the foot in an over-corrected position include the use of corrective shoes and boots, or even some form of splint.

There are instances when, after full correction has been accomplished, a tendency toward recurrence has been noted. While the actual cause of the recurrence is the contracting of fibrous tissues, it is not known why the tissue contracts in some cases and does not in others.

When this happens in the very young child, the physician might well decide to remanipulate the foot, using plaster casts and splints as was done in the very beginning. If the recurrence is noted in the older child, seven or eight years old, when the resistance of the soft tissues to over-correction is quite strong, surgery would probably be considered.

One procedure would be to cut the ligaments that hold the joints in the foot in a poor or clubbed condition. This permits the joints to open up so that they can be easily placed into the correct position and held there with a plaster cast. In healing, the defect which is made by the surgery is filled in by new fibrous tissues so that eventually the tendons and other fibrous tissues of the joints are longer than they were before the surgery.

With the accomplishments today in correcting club feet, it is no longer necessary for a child born with this defect to hobble through life as a permanent cripple. There is, of course, the occasional congenital condition which will present a problem which cannot be solved, but the majority if recognized early and given adequate treatment can be rehabilitated to a point where the individual can lead almost if not entirely a full, normal, active and healthy life.

BELIEVE ACTH LESSENS HEART DAMAGE DURING RHEUMATIC FEVER

The belief that the early use of ACTH in the treatment of acute carditis (inflammation of the heart) due to rheumatic fever will lessen the degree of damage to the heart was voiced today by two New York pediatricians.

The effects of ACTH on eleven patients, 6 to 18 years of age, were studied by Drs. May G. Wilson and Helen N. Helper at New York Hospital, Cornell University Medical Center. Six of their patients were presumably in their initial attack of rheumatic fever and in five it was recurrent. Their findings were reported in the January 20 *Journal of the American Medical Association*.

"In every patient evidence was obtained which indicated that symptoms and signs of progressive acute carditis were terminated during ACTH therapy by the third to seventh day," they reported, adding that in rheumatic fever the degree of damage usually parallels the severity and duration of acute carditis.

"From this limited experience it would appear that the early treatment of acute carditis with adequate amounts of pituitary adrenocorticotrophic hormone (ACTH) should shorten the course, result in minimal residual cardiac damage and prevent death due to progressive carditis and resultant congestive failure," they said.

The signs which the pediatricians interpreted as pointing to the reversibility of the acute rheumatic process during treatment with ACTH were: diminished enlargement of heart chambers, disappearance of murmurs denoting weakness of heart valves, electrocardiographic tracings showing disappearance of disturbance to the muscular walls of the heart and the increase in heart reserve.

The patients were reported to be ambulatory two to four weeks after treatment was begun and the symptoms and signs of active carditis in eight patients did not recur when treatment was discontinued.

"Some degree of cardiac damage was possibly sustained in all patients who received ACTH," the doctors said, but the patients were observed from four to 12 months after treatment and there was "no further evidence of increased cardiac damage" in five patients. In the six patients who were treated during what was presumed their first attack, there was no evidence of cardiac damage in two and equivocal evidence in three. No mention was made of the sixth patient.

No significant side effects attributable to ACTH were noted during its administration to patients for four to seven days or during a second course of treatment.

The report concluded:

"The duration of any one attack of rheumatic fever is self limited. The nature of the fundamental chemical changes responsible for the termination of the acute rheumatic process in the natural course of the disease as well as after stimulation of the adrenal by ACTH remains obscure."

REPORT AIR TRANSPORTATION OF MOST PATIENTS POSSIBLE

A study of the effects of air travel on 14,000 patients moved by the Military Air Transport Service between January and October 1949 shows that almost all patients suitable for transportation by other methods can be transported successfully by air.

Colonel Benjamin A. Strickland, Jr., of the U. S. Air Force Medical Corps, and Dr. James A. Rafferty, Randolph Field, Texas, said in the January 20 *Journal of the American Medical Association* that air transportation of patients proved "so successful" that it has been adopted as the "sole method" of moving patients for the armed forces.

This report is valuable to civilians as well as military personnel.

"Today," the doctors explained, "much of the available expert specialized medical care is concentrated in medical centers. In many instances patients requiring

(specialized) care must be transported to such a center.

"In general," they continued, "the routes, altitudes, weather conditions and types of aircraft utilized were identical with conditions of commercial airline operations."

A total of 16,020 case reports were made on the 14,000 patients studied. It was necessary to make more than one report on some patients if the flight was a particularly long one or if the nursing personnel changed during the course of the flight. One third of the number were litter or stretcher cases.

Only seven per cent (1,135) of the case reports recorded symptoms of any kind during flight. Most of the symptoms—due to motion, effects of altitude or the disease itself—occurred at cruising altitude but they were of a "minor nature." No ill after effects were reported.

Ninety-seven per cent of the time simple treatment relieved the symptoms. Most frequently the patient was merely asked to lie down. Only 1.1 per cent received medication and that consisted of such simple remedies as aspirin, motion sickness preventives and similar medications.

According to the report, extremely few patients were rejected for air evacuation. For example, among a random sample of 2,796 patients, only five were considered unsuitable for movement by air. The doctors added, however:

"In the selection of a patient for possible transportation by air, certain important factors must be considered. The effects of air travel on certain diseases and injuries must be viewed critically and each case considered individually. The effects of ascent to altitude, both a reduction in barometric pressure and the corresponding decrease in partial pressure of oxygen in the inspired air, may have profound effect on certain pathological conditions."

HEALTHGRAMS

Studies of 4,829 students by means of chest x-ray, tuberculin, and histoplasmin tests, conducted in the fall of 1946 and 1948, demonstrated that the distribution of the prevalence of pulmonary calcification in Ohio . . . very closely parallels the geographic distribution of histoplasmin reactors, but does not correspond to the distribution of tuberculin reactors. The prevalence of tuberculin reactors tends to be higher in the metropolitan areas and lower in rural sections. In contrast, the prevalence of both pulmonary calcification and histoplasmin reactors tends to be higher in the rural sections than in urban areas, and also shows a definite geographic pattern. Although many calcifications are undoubtedly due to tuberculosis, these facts tend to support the growing belief that most pulmonary calcifications in Ohio and other Middle Western States are probably the result of a benign widespread form of histoplasmosis or an antigenically related agent or agents. Pub. Health Rep., John A. Prior, M.D., John W. Wilce, M.D., and William Palchanis, M.D., September 1, 1950.

WANTED—Young physician to reopen the office and do general practice at Woodbine, Camden County, Ga., between Brunswick and Jacksonville. Excellent location, building fully equipped and with living quarters available. Owner away to specialize in surgery. Write JMAG, 478 Peachtree St., N. E., Atlanta, Ga.

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THE EVOLUTION OF A SPECIALTY

CURTICE ROSSER, M.D., F.A.C.S.
Dallas, Texas

The growth of specialism is unquestionably one of the most novel and striking phenomena of medical life in the United States. In excess of 78,000 physicians limit their practice to a specialty or give special attention to one of the restricted fields of medicine or surgery. It is not in the province of this presentation to discuss the wisdom or advisability of a clear majority of the physicians now practicing medicine in North America having decided that they can best serve their patients by energetically tilling a small field rather than attempting to cover in their activities and studies all of the complex branches of the art. On the other hand, many of these divisions of medicine have behind them long and almost romantic records of progress and achievement, and I believe that you will be interested in a description of the manner in which one of them evolved.

In defense of this trend to specialism, there is no question that the type of service offered to the patient has materially improved because of the increase in interest in the special fields involved. It has, for example, been illuminating to observe the disappearance of the vicious venereal disease quacks, once prominent in every American community, and to observe the gradual decline in the popularity of the one-flight-up

Main Street "stomach doctors" and "colon laundries" since the urologists of the country have offered to the public the services of a trained and interested group and since the prospective patient is now assured of the ability and special competence of the orthodox gastroenterologist. In the same fashion proctology, a field almost abandoned by the general profession to the itinerant and the charlatan, has been in recent years to a large measure reclaimed to orthodox medicine through increased realization of its importance in the general medical scheme, by provision for undergraduate and graduate instruction in anorectal disease and from a demand on the part of general practitioners that disorders so widespread in their clientele shall have the benefit of careful and scientific consideration in place of the alluring promises of the advertising quack.

While proctology as a specialty is of comparatively recent origin, medical history records that physicians have been tremendously interested in rectal pathology for many centuries. The ancients no doubt had gallbladder disease and appendices, but they could not see conditions of the internal organs and little was known or written about them. The written record of hemorrhoidal disease, for example, because it was apparent to the naked eye of the patient and the physician, because it was capable of causing profound agony in the victim, and because it was accessible to treatment, goes back some 4,000 years. An examination of such records of the past tends to induce a healthy attitude of humility in a medical

Guest speaker at the public meeting of the Medical Association of Georgia, Augusta, April 18, 1951.
President of the Southern Medical Association.
Professor and Head of the Department of Proctology, Southwestern Medical College of the University of Texas.

man in any field. It is immediately found that fundamental medical procedures do not germinate spontaneously but are slowly evolved with the turn of the centuries, and that truly "all knowledge is but a remembrance and all discovery but a forgetting". "Knowing the history of medicine is like knowing the origin of words; it is difficult to use them correctly until you understand their derivation and original meaning. Similarly, one applies current methods with much more facility if he is acquainted with the labored steps and stages of their development—the early inspiration and the early mistakes."

In olden times, as now, conditions affecting the terminal bowel were an affliction of the multitude, so much so that in the Old Testament no worse punishment could be threatened an individual or a race than to be cursed with "emerods of the hinder parts", mentioned in First Samuel, Second Chronicles and in Deuteronomy. The most ancient of all our laws and regulations comes from Mesopotamia, the land between the Euphrates and the Tigris Rivers, where man first learned to till the soil and trade its produce and where the great city, Babylon, arose and became the seat of the first great civilization. The art of writing was already well developed here fifty centuries ago. It was under King Hammurabi that Babylon achieved its earliest glory. He prepared and carved on a huge stone monument a Code which he proudly decreed was to be observed for all time. Its 282 separate ordinances regulated every phase of religious and civil life, harsh penalties being assessed for all infractions. It is known that this Code was observed through the Babylonian Empire for many centuries. The great monument which had finally been covered by the shifting sands of time was unearthed in 1901 and it was seen that the monarch, acting by command of Shamash, the Spirit

of the Sun; and Ishtar, the Goddess of Fighting and War, had not neglected the physician among his enactments. If the physician, for example, made a large incision with an operating knife to open a tumor over the eye, he was to receive ten shekels. If, on the contrary, he cut out the eye, his hands were to be cut off. The Code provided that if a doctor had cured a diseased bowel of hemorrhoids the patient should give the physician five shekels of silver.

The Ebers papyrus from Egypt dating from approximately 1550 B. C. describes hemorrhoids with associated dysentery and similar descriptions are found in Hindu writings one thousands years before Christ.

The writings of the Hippocratic school are full of references to hemorrhoids and the use of the rectal speculum is enjoined: "Lay the patient on his back and examine the ulcerated part of the bowel with the speculum". Hippocrates' works, quoted by many authorities, considered any disease about the anus as hemorrhoids and frequently as a favorable or even useful condition, attributing the "flow" to a general purification of the organism. Bleeding from the rectum formed "by the reunion of all of the wastes of the body, is made up mainly of blood of the spleen and of the bile which is drawn out; that is to say, out of the spleen, and escapes through the hemorrhoids as from the rectum". It is interesting in this connection to find that even in near modern times physicians opposed surgery for fistula in patients with tuberculosis of the lungs because they feared the wound would heal and by so doing give rise to an increase in the pulmonary disorder. Samuel Gross, one of the great surgeons of the last century, expressed this opinion stating that "we should be cautious in arresting too suddenly a discharge which has become habitual, thus throwing the onus on the more important

organ (as the lung) and inducing death prematurely."

Centuries after Christ, Galen said that ascites could be caused by blood retained in hemorrhoids just as our more recent surgical fathers spoke of "laudable pus" from a surgical wound.

Surgery concerning fistula has been referred to for almost as long a period. Hippocrates advised the use of a seton or string to gradually cut through the tract and Aelius Celsus several hundred years later advised the treatment of fistula by knife or ligation. An attitude of pessimism was present from the eleventh to the thirteenth centuries. William de Salicet of Bologna, considered the most skillful surgeon of his age, wrote in the year of 1245: "When the fistula is complete it is assuredly so difficult to cure that it is better and more honorable for the surgeon to give up the case at once". In the following century, however, John Aderne, an English surgeon, published a treatise on "Fistula, Hemorrhoids and Clysters" and laid down for the first time a principle in the treatment of fistula which is still accepted. He stated that in complete fistula it is necessary to divide all the tissues overlying the tract from end-to-end if a cure is to be effected. In spite of his wise instructions, Henry V of England was allowed to die a century later from the effects of an anal fistula while still a young man, because Hume's History of England says, "surgeons at that time had not the skill to cure."

In 17th Century France the surgeon was in disrepute, the numerous itinerants and quacks being more highly respected. Near the close of the century, however, an epochal event is said to have been more important to the prestige and consequent advance of surgery than all the teaching of the master-surgeon, Pare'. The King's fistula was oper-

ated upon. The patient, Louis XIV, had been afflicted with this disease for a year, during which courtiers and quacks extolled various remedies. The King sponsored a mass experiment, in which the most promising of these infallible remedies were applied to various of his subjects similarly afflicted. No one was cured during this year's trial and consequently the King's Surgeon in Chief, Felix de Tassy, was granted permission to incise the royal flesh.

He operated upon his sire by the technic of John Aderne, using a combination of probe and knife now known as the royal history. The operation was successful and the king's treasury in gratitude paid him a fee amounting to more than \$30,000.00; his assistant received \$20,000.00, and even the boy who carried the water buckets to irrigate the wound as the operation proceeded received \$1,000.00. The complaint then became extremely fashionable in the Court and throughout France. It is said that Louis XIV influenced medicine in three curious ways: his attack of typhoid fever gave enormous vogue to the use of antimony, his anal fistula brought about the rehabilitation of French surgery, and the fact that his mistress was attended by Clement, the royal accoucheur, did much to further the cause of male midwifery.

Because the surgical specialty of proctology in this country had its origin principally in England, proctologists have an impelling interest in the struggle of surgery itself for a place in the medical sun which offers a counterpart of the long travail through which our own specialty has passed. The forebears of the Royal College of Surgeons of England were two companies: the Barbers' Company of London and the Fellowship or Guild of Surgeons, which existed at first as separate fraternities or guilds. For many years keen rivalry existed between the two groups of surgeons but in 1540 they

were united and in 1629 Charles I granted a charter to the Company of Barber-Surgeons. Examination and approval by the Company permitted a person to practice surgery in London or within seven miles of the City. Within a few score years there were signs that the surgeons were beginning to find their association with the barbers irksome and inconvenient, but it was not until 1745 that the union was actually dissolved. It is said that it was a Cavalier, a loyal follower of Bonnie Prince Charley in his exile and "Surgeon in Order to his Person" when he became Charles II, who influenced the ruler to divorce the barbers and the surgeons and elevate surgeons from a tonsorial status to that of a respected profession. This man was Richard Weisman. He was author of a series of surgical treatises in which some thirty pages are devoted to the diagnosis and treatment of rectal disease. The surgeon, whose education traditionally was by the apprentice system, had been denied the use of a title of *Doctor* by his medical confreres of the long gown and today the English surgeon is, for this historic reason, addressed as "Mister", a title he wears proudly. The present Royal College of Surgeons was chartered by George III and all candidates for the license of the Royal College of Surgeons of England must pass the examinations of its Conjoint Examining Board.

In London surgery of the rectum and colon has been chiefly for more than a century in the hands of a group of surgeons with a special interest and consequent skill in the surgery of the bowel. While these splendid men do not designate themselves as specialists, they are combined in a Proctologic Section of the Royal Academy of Medicine, work chiefly in hospitals limited to surgery of the rectum and colon and derive their income almost entirely from this work.

Three long established hospitals in London have served as the centers for graduate and postgraduate instruction in this field, and London for this reason has long been the Mecca of the American proctologist. The Cancer Hospital on Fulham Road came into prominence because Mr. Earnest Miles was long its chief surgeon and here perfected the combined resection of the rectum which is still the most commonly used curative procedure for rectal cancer. The Gordon Hospital for rectal diseases on Vauxhall Bridge Road was founded in 1884 for the exclusive treatment of rectal diseases and named after General Charles George (Chinese) Gordon, hero of the campaigns in China, where, armed only with a walking stick he led 4,000 troupes to crush 4 million taipings, forerunners of the present day Chinese Communists. Originally an institution with only 38 beds, it has been during recent decades entirely rebuilt through the generosity of a prominent British distiller who was the grateful patient of the same Mr. Miles who was also, during his lifetime, the chief surgeon of this hospital.

The real fountainhead of European teaching and practice of proctology is St. Mark's Hospital for Cancer, Fistula and other Diseases of the Rectum. The venerable institution on City Road, London, was opened in 1835. The original address could properly be reissued at the present date.

"Human suffering, in whatever form it may appear, will always be an object of interest to the benevolent mind. It is a matter of deep lamentation that diseases of the severest kind, which secretly impair and undermine the constitution, and involve a degree of personal distress appalling to be contemplated, pass too often comparatively without regard, because they do not obtrude themselves upon the public notice.

"There is only too good reason to believe that the afflicted poor, having in vain sought for relief, have abandoned themselves to the unprincipled empirics, who, after exhausting their scanty means, have consigned them, hopelessly to a miserable existence or premature grave.

"This institution claims the merit, not only of affording relief to the poorer members of the community, but it further confers the important and peculiar benefit of detecting latent and, if not discovered, fatal afflictions, and of administering (under the favor of



FIG. 1.
St. Mark's Hospital, London, Today.

Divine Providence) effectual alleviation, if not permanent cure."

Sixty years ago surgery in the United States was in the chrysalis stage of its brilliant future. Individual stars, among them the Emperor of American Surgeons, the elder Samuel Gross of Philadelphia, Nicholas Senn of Chicago, and Tiffany of Baltimore were attracting large galleries. Soon Pasteur was to announce his monumental discovery and the "germ theory" to be accepted by thinking surgeons of this country. But rectal surgery, relegated to itinerants and charlatans, had actually become a part of an ingenious and almost mystical philosophy called "Orificial Surgery."

A book called "Orificial Surgery and Its Application to the Treatment of Chronic Diseases" was written by E. H. Pratt in 1891, and published by Halsey Bros. of Chicago. The writer describes the philoso-

phy of his school in the following words: "If the blood current is strong and free, health is assured; if, on the other hand, the general circulation is sluggish or local congestions occur, morbid processes especially of the sympathetic nervous system are of necessity initiated. 'Orificial philosophy' is based on the theory that irritation of an organ begins at its mouth and from these chronic pathologic conditions including insanity and neurasthenia may develop from local congestion and nerve-waste."

The author lists the following procedures for his standard operation: "Slit the foreskin or free the clitoris of the patient, enlarge the meatus, sound the urethra, excise portions of the labia, amputate caruncles, remove the hymen, dilate the vagina and the cervix and, finally, explore the rectum and remove all pockets, papillae, hardened feces

and other forms of rectal pathology." What better illustration of the lack of interest or intensive study on the part of orthodox physicians of the United States in connection with the treatment of diseases of the rectum and colon.

It was at this time that the surgeon who was to lead in the development of the specialty of proctology in the United States, Joseph M. Mathews of Kentucky, determined to gain more accurate information concerning the field. It is fortunate that Mathews obtained his graduate training in London. The group of surgeons working at St. Mark's then under the leadership of Mr. William Allingham had developed sound diagnostic principles and advanced surgical methods in the treatment of diseases of the colon and rectum. Mathews brought back from London to the United States, to offset the injection treatments, orificial operations and almost ludicrous propaganda of those who practiced proctology in the medical twilight, the better diagnostic and surgical methods which characterized the London of his day. One year after he returned and established offices in the Masonic Temple, he became Professor of Surgical Pathology of the Kentucky School of Medicine. Four years later a Department of Rectal Diseases was created in this school and Mathews was given the chair. According to his former students he was a man of great personal force, an orator; a man well informed on public matters; a gifted story teller with a marked sense of humor. There can be no doubt of his popularity with fellow physicians, as well as his interest and ability in the work of all the medical organizations with which he was associated. Due to his mental and oratorical ability almost every such organization elected him to its presidency. The long list begins with the Louisville Surgical Society and proceeds to the Kentucky State Medical Association and

the Mississippi Valley Medical Association, and finally, in 1899, he became president of both the newly-organized American Proctologic Society and the American Medical Association. The tremendous number of contributions to the literature which flowed from his pen present a realistic and frank picture of current opinions concerning diagnostic problems and the management of all the usual diseases of the rectum and "flexure," as Mathews termed the rectosigmoid canal. His reasoning was intelligent and his conclusions were usually characterized by common sense and honesty. It is true that his observations were limited by the lack of instruments which we now regard as essential, but if some of his writings seem to present incorrect conclusions, viewed in the light of present knowledge and accomplishment, let us only hope that the next half century will deal as kindly with our own opinions.

Mathews was the prime contribution of the South to this infant specialty but other Southern physicians have aided in the evolution of the American specialty of proctology. When the American Proctologic Society was founded in 1899 four Southern proctologists were present: Mathews of Louisville, Earle of Baltimore, Cooke of Nashville and John L. Jelks of Memphis, who served as its president in 1911. Dr. Emmett H. Terrell of Richmond became interested in proctology in the early part of 1911 and sought out Dr. James Tuttle of New York City as a preceptor. Dr. Terrell returned to Richmond in 1913 and began the practice of proctology, there being no other specialist in this field in Virginia at the time. He became Clinical Professor of Proctology in the Medical College of Virginia and was the twenty-third president of the American Proctologic Society. The members of our specialty honor the pioneer activities of Dr. Marion C. Pruitt of At-

lanta, fellow of the Royal College of Surgeons of Edinburg, author of textbooks, former president of the American Proctologic Society, the founder of the Section on Proctology of the Southern Medical Association and at present member of the American Board of Proctology.

The Specialty Boards which now examine and certify specialists, much as the old Guilds and Companies of England and other European countries regulated the practice of various fields of medicine and allied arts, originated some twenty years ago and have become an increasing force in medical practice, determining to some extent the eligibility of physicians for hospital and medical school appointments.

The specialty of proctology sought approval for an American Board beginning in 1934 but the Board itself was not established as an independent and autonomous body until June of 1949, with Dr. Louis A. Buie of Rochester, Minnesota, an outstanding leader, as its Secretary-General. Thus culminated many years of organized effort to secure proper recognition of a field in which the average general surgeon had little interest or knowledge but was still reluctant to relinquish. The best index to the gradual but impressive growth of interest among physicians in this branch of surgery is the membership roll of the American Proctologic Society—from 13 in 1899 to 500 in 1951. World War II stimulated a demand for training facilities which is only now being properly met and the establishment of an American Board now offers those of us concerned a welcome opportunity to supervise the training of those who use these new graduate facilities and thus in some measure keep our representatives in the profession on the highest educational level.

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THE HEART IN HYPOTHYROIDISM

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A form of heart disease associated with myxedema has been recognized as a clinical entity since it was first proposed by Zondek^{1,2} in 1918. In his classic paper he described the characteristic features of marked enlargement of the heart, slow pulse rate and electrocardiographic changes. The fluoroscopic appearance of the heart was depicted as a "lifeless, expressionless mass with deformed contour." He noted further that following thyroid therapy all the abnormal findings disappeared. Zondek's observations were subsequently confirmed by Assmann,³ Meissner,⁴ Fahr,⁵ Sturgis,⁶ Means,⁷ White⁷ and others.

Cardiac complications in myxedema are not rare. McGavarack, et al.,⁸ observed 24 patients with frank myxedema and cardiac complaints over a period of four years in a general city hospital. The temptation to limit the cardiac changes occurring in thyroid deficiency subjects to those individuals with frank myxedema has existed since Zondek's original report. Little attention has been paid to the presence of a similar form of heart disease occurring in subjects with hypothyroidism of insufficient severity and duration to be classified as myxedema.

In 1941 Zondek⁹ reported a case which he termed "abortive myxedematous heart." He described a patient in whom the fully developed clinical picture of myxedema was not present. The patient had an enlarged heart,

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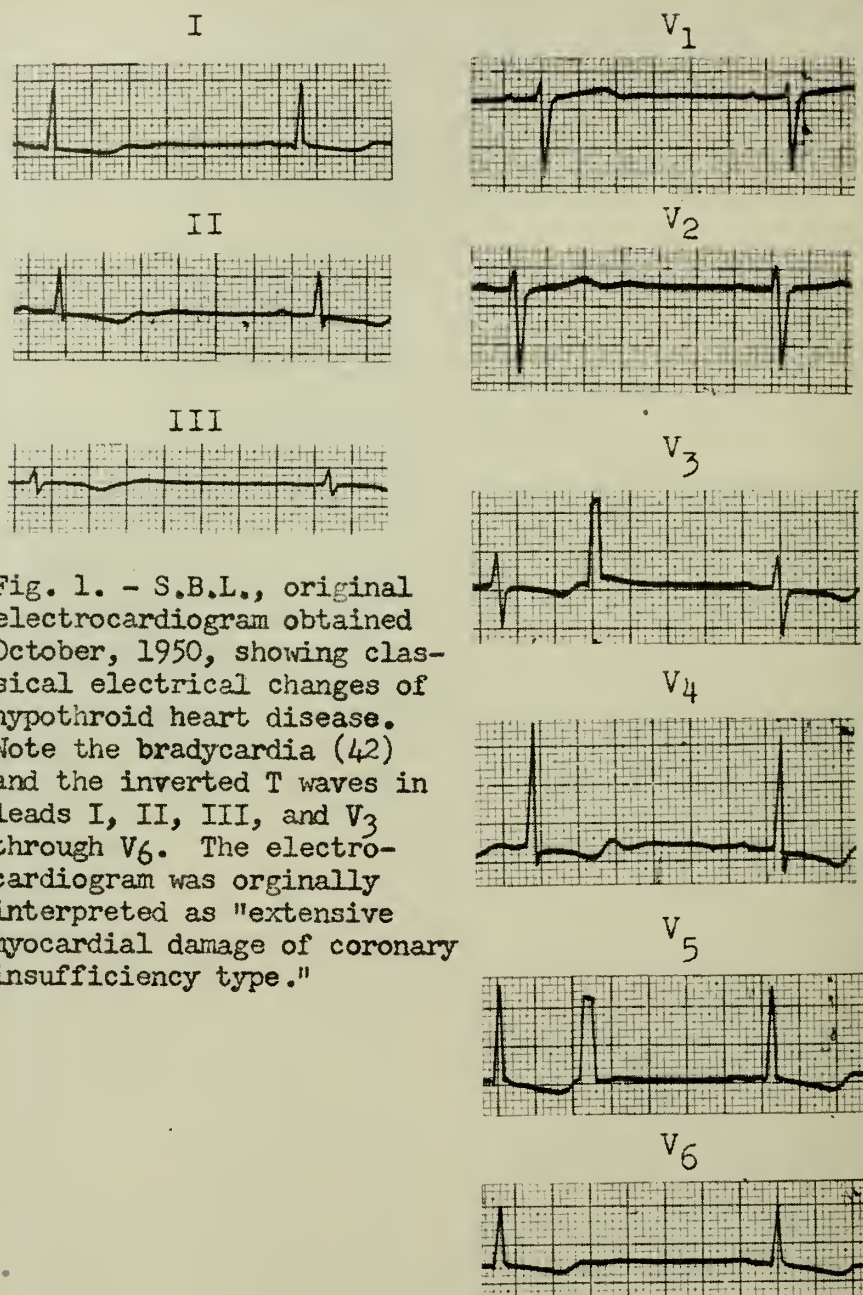


Fig. 1. - S.B.L., original electrocardiogram obtained October, 1950, showing classical electrical changes of hypothyroid heart disease. Note the bradycardia (42) and the inverted T waves in leads I, II, III, and V₃ through V₆. The electrocardiogram was originally interpreted as "extensive myocardial damage of coronary insufficiency type."

bradycardia, low basal metabolic rate, elevated serum cholesterol and symptoms of angina pectoris, all of which findings reversed following thyroid therapy. Recently Ljung¹⁰ called attention to four cases of hypothyroidism in which cardiac abnormalities were discovered although the typical myxedematous syndrome was absent.

One of his cases had been receiving anti-thyroid medication (methyl-thiouracil); another case had a subtotal thyroidectomy nine months previously; his third case had been treated for many years unsuccessfully with digitalis for heart failure of undiagnosed etiology; and his fourth case had been incorrectly diagnosed as "subacute

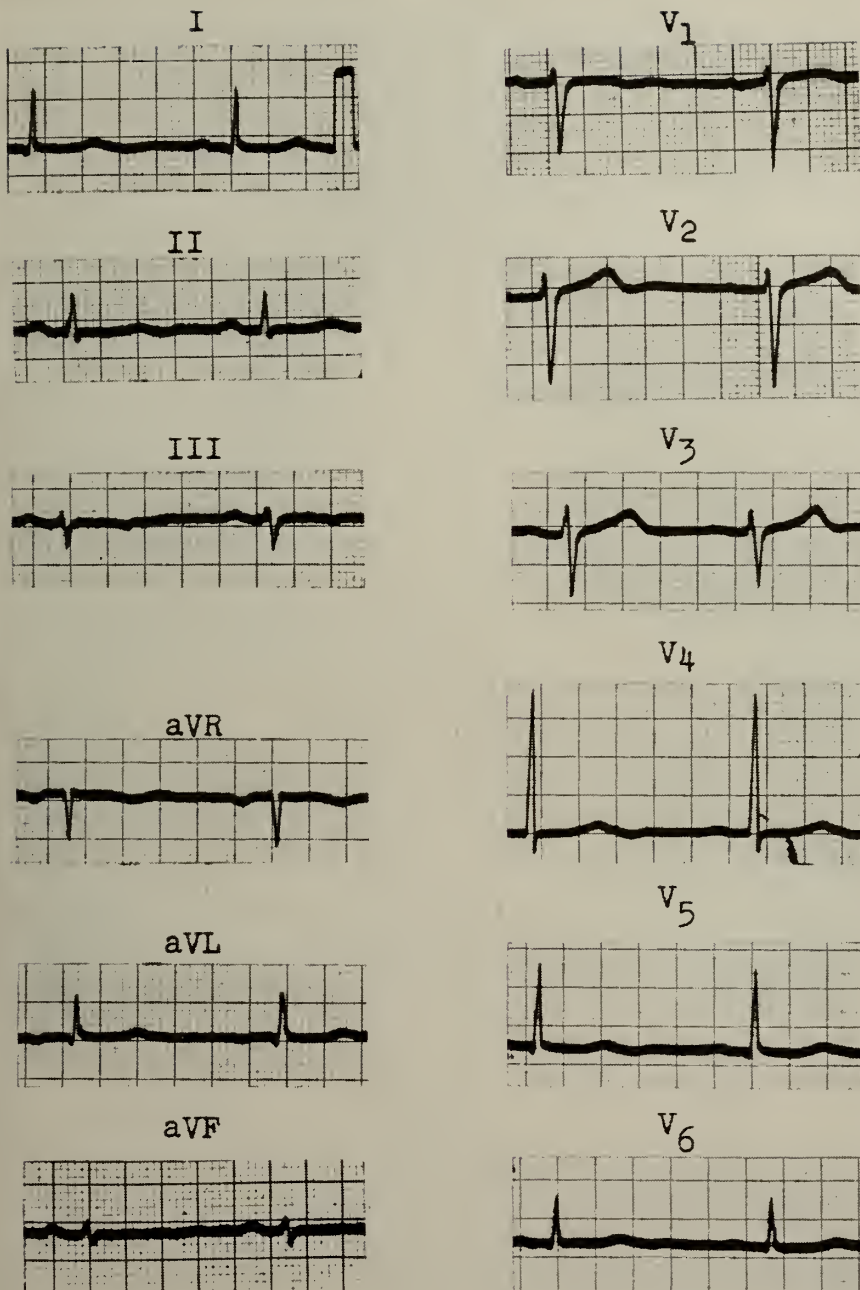


Fig. 2.—S.B.L., electrocardiogram taken two months after institution of thyroid medication (December, 1950). The T waves in leads I, II, and V₃ through V₆ are upright. The EKG is now within normal limits. Marked clinical improvement accompanied the electrocardiographic changes.

myocarditis" primarily on the basis of the electrocardiographic alterations.

The customary medical textbook description of myxedema is identical with that originally described by the Commission of the Clinical Society in 1888,¹¹ which was based

on the most advanced stages of the disease. The characteristic facies, the mental retardation, the thickened tongue and the skin changes are the features which are particularly emphasized. In practice such abnormal cases are rarely seen. If discovered,



Fig. 3.—S.B.L., original chest x-ray obtained in October, 1950, showing generalized cardiac enlargement.

chances are likely that medical advice was avoided or proven inadequate. Marked myxedematous alterations develop slowly over a period of months or years during which time the patient has an incomplete form of hypothyroidism. It is during this stage when important cardiac changes may appear. Care, on the other hand, must be taken to avoid confusing individuals with true hypothyroidism from those patients with an abnormally low basal metabolic rate due to hypometabolism from causes other than thyroid deficiency. A lowered basal metabolic rate does not necessarily imply a lowered rate of production of the thyroid

hormone. The terms hypothyroidism and hypometabolism are not synonymous. In hypothyroidism enough hormone is formed to avoid the manifestations of myxedema, but not enough to meet normal minimal requirements of the bodily functions, including the heart. Unless clinicians are aware of hypothyroid heart disease the cardiac changes may be incorrectly diagnosed or go unrecognized for prolonged periods of time.

Interest in this form of heart disease was fostered by the study of the following case which is presented briefly:

CASE REPORT

S.B.L. was a woman aged 54 who had been married 36 years and had two living children. The onset of a complicated menopause occurred in 1946. In October

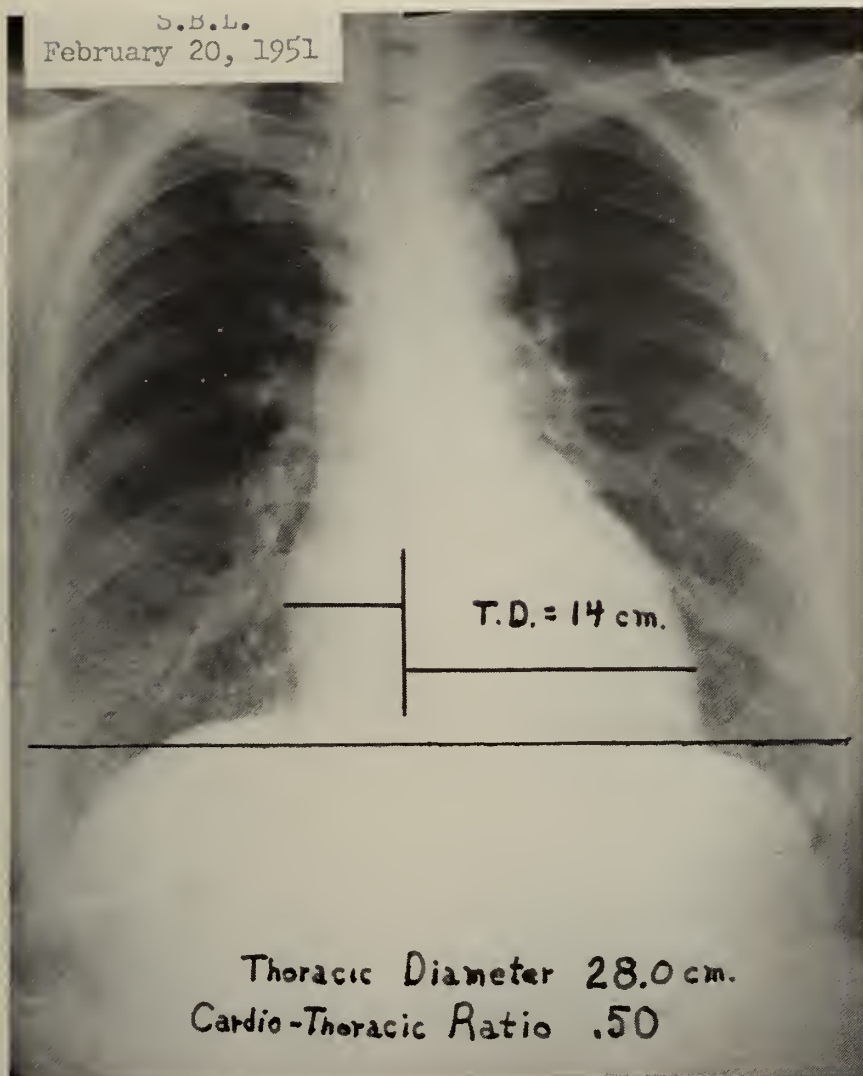


Fig. 4.—S.B.L., chest x-ray taken in February 1951, after four months of thyroid therapy. There is a significant decrease in the size of the cardiac silhouette as well as increased cardiac contractions fluoroscopically.

1948 she had a hysterectomy for a grade one cancer of the cervix. She had always had difficulty in keeping her weight down and considered herself a "nervous woman". In the spring of 1949 she began to complain of excessive weight again, lassitude, easy fatigability, insomnia, and vague muscle and joint pains. The diagnosis of menopausal syndrome, arthritis, obesity, and neurosis had been considered by various physicians. She consulted an otolaryngologist in April 1950 because of persistent hoarseness and he suggested thyroid administration which was voluntarily discontinued after a short period of time. Edema of hands and feet, exertional dyspnea, and puffiness of the eyes appeared in August 1950, becoming progressively worse.

In October 1950 she consulted another physician who in the course of his examination discovered her basal metabolic rate to be minus 20 per cent, serum cholesterol 320 mg. per cent, blood pressure 112/60, and an x-ray of the chest revealed diffuse enlargement of the cardiac silhouette. Because her electrocardiogram was interpreted as "extensive myocardial damage", she was referred to me for complementary electrocardiographic examination prior to digitalization. The non-specific T wave inversion and sinus bradycardia (rate of 42) were pathognomonic of hypothyroid disease. There was no evidence of thickened tongue, sluggish

speech, or expressionless facies to warrant a clinical classification of myxedema.

The administration of $\frac{1}{2}$ grain thyroid substance daily was initiated in October 1950. By December 31, 1950 her edema, exertional dyspnea, muscle and joint pains, lassitude, and fatigability had improved considerably. Her heart size had diminished. Cardiac contractions on fluoroscopy were more forceful. The T waves in the electrocardiogram had become upright, although the bradycardia (58) persisted. Thus the improvement in her cardiac status following the administration of thyroid substance verified the diagnosis of hypothyroid heart disease, which condition was originally suggested on the basis of the electrocardiographic findings alone. Fortunately, digitalis which may have confused the picture was not given.

Symptomatology

The subjective symptoms of hypothyroid heart disease are negligible unless complicated by angina pectoris. Objective findings are cardiac enlargement, sluggish heart action, electrocardiographic changes and the

clinical manifestations of the associated disease. The electrocardiographic, fluoroscopic and radiologic tests provide indispensable diagnostic evidence and should not be omitted in evaluating cases of thyroid deficiency.

The clinical manifestations of the disease hypothyroidism are also nonspecific, being suggestive rather than diagnostic. In the early stage such vague symptoms as easy fatigability, weakness, somnolence, sensitivity to cold, and weight gain appear. As the disease progresses the mental and bodily reactions become retarded which is more apparent to the family and friends than to the patient. These prodromal signs are followed by dryness of the skin, diminished sweating, puffiness of the eyes and tendency for the hair to fall out. This stage may last for years. Stiffness and aching in the joints and muscles, hoarse low pitched voice, and anemia may prompt a diagnosis of menopause, arthritis, obesity, or neurosis. Exertional dyspnea, edema of hands and feet, and cardiac enlargement suggest congestive heart failure. Finally the typical myxedematous coarse facial features appear; the tongue becomes thick; and the speech is slow and muffled. The degree of progression in the course of the disease when changes in the heart appear will vary. The early recognition of cardiac alterations is aided considerably by the electrocardiographic picture which can provide one of the first clues to the correct diagnosis.

Cardiac Manifestations

Zondek's original observations of diffuse enlargement of the heart, sluggish cardiac contraction and electrocardiographic abnormalities have been confirmed without substantial change. Stewart and Evans¹², Lange,¹³ and Blumgart, et al,¹⁴ showed that the cardiac output, circulating blood volume, velocity of blood flow, pulse rate, pulse pressure and vital capacity were all decreased when the basal metabolism was low.

The cause of the enlargement of the cardiac silhouette is uncertain. Pathologic data is scanty with conflicting reports appearing in the literature. Bell¹⁵ described hydropic degeneration of cardiac muscle fibers. Schultz¹⁶ observed a homogeneous infiltration which stained blue with hematoxylin. Grossly the muscle has been stated to appear edematous.¹⁷ The fact that hypothyroidism predisposes to coronary arteriosclerosis complicates the picture. Fahr¹⁸ in a single autopsied case described enlargement of the heart, arteriosclerotic occlusions, and necrosis of the myocardium. It is generally agreed that coronary thrombosis and myocardial infarction occur with unusual frequency in patients with myxedema so that arteriosclerotic heart disease may on occasion be one of the factors contributing to the increased size of the cardiac shadow. The reversibility of the cardiac enlargement however, when thyroid is administered or withdrawn suggests that there is no true hypertrophy of the myocardial fibers but rather that the enlargement is due to a homogeneous infiltration or interstitial edema similar to that in the skin.¹⁹ Pericardial effusion has been reported to be a fairly constant finding and may also partially contribute to enlargement of the cardiac silhouette.²⁰

Many of the signs and symptoms accompanying advanced hypothyroid or myxedematous heart disease may be confused with other conditions. The enlarged cardiac silhouette, the pericardial effusion, the peripheral edema, the exertional dyspnea, the abnormal electrocardiogram, the elevated serum cholesterol, and the anemia resemble the findings in congestive heart failure or the nephrotic syndrome. Nephrosis can be eliminated by additional laboratory tests particularly those involving renal function. Congestive heart failure may be differentiated by the "adynamic" character of the

features in hypothyroidism which consist of slow pulse rate, sluggish heart action, dyspnea on exertion but no orthopnea, absence of pulmonary and hepatic congestion, and low basal metabolic rate. The "dynamic" signs characteristic of heart failure such as tachycardia, marked dyspnea, pulmonary and hepatic congestion, elevated venous pressure, and dependent edema are lacking. The cardiac manifestations in advanced hypothyroidism are more truly a reflection of the disease hypothyroidism than of the heart *per se*.

Electrocardiographic Changes

The almost universal availability of the electrocardiogram has rendered the cardiographic record a most practical method to the clinician for the detection of many conditions, one of which is hypothyroid heart disease. The electrical alterations associated with the heart in hypothyroidism have been described as consisting of (1) flattening or inversion of the T waves, (2) sinus bradycardia, (3) low voltage of the QRS complex and P wave, and (4) reversal of these changes following thyroid therapy.²¹ It should be pointed out that correlated with the various stages of any disease process is a series of gradations or developing electrical alterations. The fact that the fully developed abnormal electrocardiographic picture is not always present demands consideration in the interpretation of the cardiogram in hypothyroid heart disease.

The most reliable and constant electrocardiographic features are the sinus bradycardia and the flattened or inverted T waves, especially in the left precordial leads V₄, V₅, V₆), and leads I, II, and lead aVL or aVF depending upon the electrical position of the heart. The presence of inverted T waves in the above leads without significant S-T segment elevation or depression indicates a nonspecific type of abnormal record. Such a record could conceivably be con-

fused with atypical myocardial ischemia or pericardial disease although the history and serial electrocardiograms should establish the correct diagnosis. The advisability of interpreting low voltage of the QRS complex as an electrocardiographic criterion is hazardous since the recorded voltage is governed by many extracardiac factors; namely, skin resistance, the state of the heterogeneous conducting tissues of the body, the shape of the chest, and the distance of the precordial electrode to the heart. A QRS complex of low amplitude may, however, be produced by pericardial effusion, because the pericardial fluid short-circuits the electric current generated by the myocardial fibers. If an appreciable increase in the QRS amplitude appears following thyroid medication, the previously small QRS complex may then be considered to have been of diagnostic significance. Various degrees of partial heart block have also been reported in this condition although such conduction disturbances are not a constant finding. Unless restoration of the normal conducting mechanism occurs following an adequate trial on thyroid medication, the heart block is to be considered a manifestation of superimposed cardiac disease.

The cardiographic record as an objective test in the diagnosis of hypothyroidism cannot be overemphasized. The mechanical alterations, as demonstrated by x-ray and fluoroscopy, are not so specific as the electric changes. The combination of inverted T waves without S-T segment deviation and sinus bradycardia is almost pathognomonic and should raise suspicion of a thyroid deficiency condition (provided digitalis medication has not been given.) In two of Ljung's¹⁰ four cases the correct diagnosis was initially suspected on the basis of the cardiographic findings alone.

If arteriosclerotic heart disease is superimposed on the hypothyroid heart, electro-

cardiographic abnormalities may persist following thyroid medication. These residual changes must not be misinterpreted since over-administration of thyroid substance in such cases can lead to serious consequences.

Treatment

Because of the difficulties in differentiating the thyroid deficiency state from other conditions, objective tests are most important. The detection of a low protein bound blood iodine value, a low basal metabolism, an elevated serum cholesterol, and characteristic cardiographic changes are very suggestive. The diagnosis, however, is not established until the clinical, biochemical, and electrical abnormalities are reversed following thyroid medication.

Thyroid substance must be administered cautiously and in small doses. The hypothyroid subject, particularly if the condition is of long standing, exhibits a peculiar initial hypersensitivity to thyroid medication which disappears later. If accompanying severe coronary arteriosclerosis is present the increased metabolism and increased work of the heart associated with thyroid administration may result in considerable myocardial embarrassment. An anemia, if present, can further embarrass the situation. Concomitant cardiac damage from pre-existing myocardial infarction, hypertensive or beri-beri heart disease reduces the cardiac reserve and if large doses of thyroid are given, intractable angina pectoris, myocardial infarction, or congestive heart failure may ensue.

The initial dose of thyroid substance should not exceed 0.03 grams (one half grain) or preferably 0.008 grams (one eighth grain) daily. Gradually increasing increments of thyroid should be given over a period of days or weeks according to the clinical response of the individual. Winkler²² advocates interrupting the thyroid

medication for two or three days after the first two or three doses have been given. With satisfactory treatment over a period of four to eight weeks there is a striking diminution in the size of the heart, a reversal of the electrocardiographic abnormalities, and an increase in the pulse rate, cardiac output, circulating blood volume, velocity of blood flow and basal metabolism. Serial electrocardiographic tracings as well as protein bound blood iodine values aid considerably in following the progress of thyroid therapy.

Digitalis is of no benefit and is not indicated.²³ The use of morphine may be dangerous since its toxic effects in hypothyroidism are greatly increased. In occasional cases of severe coronary arteriosclerosis residual symptoms which must be interpreted as those of congestive heart failure may appear following thyroid medication. Digitalis and other measures for the control of heart failure should then of course be instituted. In some patients with underlying cardiac disease the maintenance of the patient at a slightly hypothyroid level is advisable. It should be emphasized that thyroid replacement therapy must be carefully, cautiously and intelligently administered.

Conclusion

Attention is called to a form of heart disease occurring in hypothyroid subjects whose condition is of insufficient severity and duration to be classified clinically as myxedema. Generalized cardiac enlargement, electrocardiographic changes, slow pulse rate, and sluggish cardiac action, are the characteristic features. The electrocardiographic picture is almost pathognomonic, the most reliable alterations in the record being the sinus bradycardia and the flattened or inverted T waves. These electrical changes enable early recognition and prompt treatment of a condition which has a favorable therapeutic and prognostic outlook and which, if undiagnosed, predisposes to arteri-

sclerosis. It should be emphasized that the subjective symptoms of hypothyroid heart disease are negligible. For this reason the clinician as well as the cardiographer should keep this form of heart disease in mind.

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THE PROBLEM OF CHRONIC RECURRENT URTICARIA AND ANGIOEDEMA

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Isolating the etiologic factors of chronic recurrent urticaria and angioedema is by no means a simple procedure and often-times is not successful. I believe the most practical approach to this problem is by a careful his-

tory, physical examination, and laboratory procedures. It is the exception rather than the rule to perform skin tests. However, there are exceptions to this. The recognition of the importance of intestinal parasites being the cause of chronic urticaria has been expressed by (1) Cooke, (2) Vaughn and many others. Most of us in the field of medicine are well acquainted with this fact. However, there is no question that this type of urticaria is more common in the South and tropics than elsewhere. I wish to emphasize especially the important role that intestinal parasites play in this problem and this paper will be primarily devoted to this phase of the subject. However, the reason for presenting this subject is because everyone in the field of medicine is confronted with this problem at one time or another. I should like to relate 105 cases of chronic recurrent urticaria and angioedema caused by hookworm infestation found during the past three years. The majority of these patients lived in rural areas.

In "hookworm urticaria" only 25 per cent of the cases gave a history of familial allergy. Most all cases were worse during the summer months (May through October).

The procedures employed are as follows:

1. History.
2. Physical examination.
3. Complete blood studies.
4. Complete urine studies.
5. Stool examinations (at least three specimens).

The ova of *Necator Americanus* were found in all of my cases. All of these 105 patients were treated with two bouts of Hexylresorcinol, each treatment one week apart, and stool studies were repeated the third week. If the ova were still found, the patients were again treated in a similar manner. Ninety per cent of the cases became asymptomatic after the first treatment and of the remaining 10 per cent, 6 per cent became asymptomatic after the second treatment. Additional treatment was necessary in only 4 per cent, and this was due to

failure of the patient to follow directions. I might add that 40 other patients were infected with hookworm but I have been unable to follow their cases; whether the parasites were the secondary or the primary cause is impossible to state.

The lack of peripheral blood eosinophilia is of little significance. However, when present it may be helpful, but if not present one should still be suspicious of possible *Necator Americanus* infestation. Seventy-four cases showed definite eosinophilia while 41 cases gave a normal differential count. Forty eight cases had a hemoglobin of less than 70 per cent (Salhi).

Three months follow-up on all 105 cases showed no recurrence of urticaria or angioedema, with one exception in which case this patient either became reinfested or was not cured of hookworm disease, but subsequent studies and observations have been negative.

Symptomatic treatment of chronic cases is general. The most commonly employed drugs and procedures follow:

1. Antihistamines (by mouth, intramuscularly, or intravenously).
2. Ephedrine and related compounds.
3. Epinephrine (usually in oil).
4. Aminophyllin (intravenously).
5. ACTH (12 cases).
6. Cortone (6 cases).
7. Histamine.
8. Calcium gluconate—of NO value.
9. Autohemotherapy.
10. Other foreign proteins (sterile milk, etc.).
11. Vitamin K.
12. Splenic extract—very limited value.
13. Sedation.
14. Local lotions, baths, etc.

Briefly, other causes of chronic urticaria and angioedema are as follows:

1. Foci or focus of infection.
2. Parasitic infections (intestinal parasites as well as malaria. Also insect bites, such as mosquito, bees, etc.).
3. Drugs, such as penicillin, liver extracts, serums, etc.
4. Foods (the most common are eggs, milk and wheat).
5. Inhalants (flaxseed, some pollens, and cottonseed).
6. Contact allergens (silk, dyes, and plants).
7. Physical allergies (ultraviolet rays and cold).

I would also like to mention a few other non-allergic causes:

1. Endocrine dyscrasias (pregnancy, menstruation, hypothyroidism, etc.).

2. Psychogenic factors (may be primary or associated with an allergy).
3. Blood dyscrasias (anemia, leukemia, Hodgkin's disease, etc.).
4. Gastrointestinal (achlorhydria).

In these complex cases I have only been able to isolate the causative factor in 60 per cent of the cases. Cooperation from the patient is very important but not often obtained. Food diaries and careful observations by the patient will frequently assist us.

In summary, I have tried to briefly outline the most common causes of chronic recurrent angioedema and urticaria with special reference to intestinal parasites. I wish to emphasize the importance of studying more than one stool specimen, and preferably three or more if you are suspicious of parasitic infestation.

REFERENCES

1. Cooke: Allergy in Theory and Practice, p. 303.
2. Vaughn and Black: Practice of Allergy.

BRONCHIOGENIC CARCINOMA IN A TWELVE YEAR OLD BOY

WALTER G. THWAITE, M.D.

Quitman

My paper today is the case report of a 12 year old Negro boy. On December 5, 1950 the boy was brought to my office by his parents. He complained of pain in the left lower chest posteriorly and in the left infra-axillary area of a week's duration. The pain was not severe, was fairly constant, and was increased with inspiration. A slight nonproductive cough, also of a week's duration, was complained of. On examination, the boy appeared ill, but not extremely so. He was poorly nourished. Respiration was accelerated and there was a slight flaring of the nostrils with inspiration. His temperature—this was mid-morning—was 100 F. The chest showed an impaired percussion note beneath the left scapula extending to the left infra-axillary area. Over this area

there were crepitant inspiratory rales. The patient was thought to have a left lower pneumonia, and was given an injection of 400,000 units of penicillin, procaine aqueous. A combined triple sulfonamide-penicillin tablet (Pentressamide) was prescribed, one every 4 hours day and night, and an expectorant cough mixture was given. No analgesic was prescribed as the pain was described as mild. The patient was allowed to go home.

Eight days later the boy was seen again at the office. The cough was described as better, but he complained now of pain in the left anterior chest, more severe than before. He appeared acutely ill and his breathing was labored. The nostril flaring on inspiration was marked, and there was a slight expiratory grunt. His temperature was 99 F. The change in his chest findings in so short a time was disturbing. There was flatness to percussion over the entire left chest except for the apex. Breath sounds were absent or very faint over the chest except the apex anteriorly where there were inspiratory and expiratory moist rales. The impression was that of a massive pleural effusion following pneumonia. The patient was hospitalized.

The hospital admission temperature was 101 F., the white cell count was 16,250 with 73 per cent polys. X-ray of the chest showed marked density of most of the left chest with the heart displaced to the right. The patient was given penicillin procaine aqueous 300,000 units every 24 hours and dihydrostreptomycin 0.5 gram every 12 hours. Chest tap was done and about 300 cc. of blood tinged fluid was obtained. The fluid showed no organisms on direct smear, and no organisms were grown on blood agar. Tubercle bacillus culture and animal inoculation were done, and later negative reports were received.

After the chest tap, the patients dyspnea

was relieved slightly, but his temperature rose to 104 F. There was a gradual fall from this level to 100 where it stabilized. The next day chest tap was done again and only 60 cc. of similar fluid was obtained. Two days later the chest was tapped again and approximately 120 cc. of fluid was obtained. This fluid was bloody. The chest was x-rayed again, and there was little change from the previous film except that the left apex was clearer. The two chest films were sent to Dr. John Collins, Thomasville, for his opinion and he reported: "There is a very marked density over the major portion of the left hemithorax. There is some displacement of the heart to the right. The appearance indicates the presence of a large amount of fluid in the left pleural cavity. The upper border of the fluid is not the usual contour of fluid and this is suggestive of the probability of encapsulation of the fluid in the pleural cavity. It would be well to aspirate this patient's chest again, and if only a small amount of fluid is obtained it would be well to aspirate at different areas in order to be sure that an encapsulated collection of fluid is not being missed because of walling off of portions of the fluid in the pleural cavity."

Numerous chest taps were done at different points, with only a few cc. of fluid obtainable. At one of these some small particles were withdrawn with the fluid. These were sent to Dr. E. B. Saye, Thomasville, for examination. I had hoped there might be cellular elements in the particles, but Dr. Saye reported: "There is no organized tissue present. Throughout the mass of red blood cells there are scattered areas of fibrin with entangled leukocytes and blood platelets. There is nothing in any of the sections to explain the etiology of the hemorrhagic character of the fluid."

The patient continued to exhibit a distressing picture of air hunger, moderately

high fever and wasting. The cardiac impulse was now seen 4 cm. to the right of the midline. He appeared anxious and was unresponsive to questioning. On January 4, without having previously complained of pain or numbness, the patient developed paralysis of both legs. This was flaccid with absent reflexes, and pain appreciation was lost. There soon followed sphincter paralysis of the bladder and rectum. From here to the boy's death, on January 27, there was progressive increase in breathing difficulty. The last two weeks he complained of severe chest pain and of pain in the left arm, and morphine was given frequently. The patient died January 27 and permission was obtained for postmortem examination of the chest.

On exposing the thoracic contents the left pulmonary pleura was grey in color, and adherent to the displaced pericardium and to the parietal pleura. It had the feel of a thickened crust or shell containing fluid. On cutting through this shell of pleura and lung periphery, it was a shell indeed filled with grey lung tissue reduced to a liquid and soft solid state. In the upper posterior portion of the destroyed and liquified lung, where its adherence to the posterior chest wall was densest, was a firm irregular mass the size of a large lemon. This was attached to the main bronchus to the inferior lobe of the left lung. At the hilus was another smaller nodularity. The right lung showed three small spherical nodules raised above its surface. The 10th thoracic vertebra showed on its left anterolateral surface a soft nodularity which when cut into was of the consistency of brain tissue.

Specimens were submitted to Dr. Saye who reported: "The lung tissue is extensively involved by a malignant epithelial neoplasm. In some areas the tumor is papillary in arrangement, with papillae covered by layers of cells which vary from spindle-

shaped to polygonal, and in a few of which are atypical glands. Mitoses are numerous and there is nuclear hyperchromatism. The spherical node appears to be a metastasis and consists of a diffuse growth of undifferentiated neoplastic cells. There are a variety of incidental lesions: necrosis, thrombosis, atelectasis, and fibrosis. Diagnosis: Bronchiogenic adenocarcinoma of left lung with metastases, grade III."

Here then is the case of a 12 year old boy who within eight and a half weeks of the appearance of his first symptoms was dead of a bronchiogenic carcinoma of the lung.

After the boy's death additional history brought out that for 2 or 3 weeks before his first visit, he had on occasion mentioned a choking sensation as though his food would not go down. During this period his teacher had noticed that he did not play very much at school and had complained of being tired. In 1949, during a county-wide VD-TB detection survey, the patient had had a chest x-ray. He was called back for a second examination, and his parents were told that he had an enlarged heart. I tried to obtain the report of his x-ray and also the films, but these were filed according to serial number with no cross-reference for names, and the Board of Health could not obtain them for me.

HEALTHGRAM

The necessity for mass x-ray study of the population, such as the one just completed in metropolitan Boston, is demonstrated by the fact that only a fourth of all new cases are traceable to known cases of tuberculosis. This finding indicates the existence of a large unrecognized reservoir of bacilli, which is a possible source of infection to many susceptible persons. Only by the extension of case finding by mass x-ray examinations of large population groups can people suffering from incipient tuberculosis be assured of a reasonable chance for arresting the disease and returning to their homes as self-sustaining, independent citizens. These community surveys are especially important in that they reveal cases in this early, hopeful phase of the disease; 60 to 70 per cent are minimal, compared with a 10 to 15 per cent minimal stage reported by other methods of case finding. Ed., *The New England J. Med.*, April 20, 1950.

LIGATION OF EXTERNAL CAROTID ARTERY AS AN EXPEDIENT IN CONTROLLING PROLONGED NASAL BLEEDING.

Report of Two Cases

MURDOCK EQUEN, M.D.

FRANK BUCKNER, M.D.

GEORGE ROACH, M.D.

ROBERT BROWN, M.D.

Atlanta

Introduction

Arterial bleeding deep in the nasal cavities may present an emergency which defies all of the commonly accepted methods of controlling hemorrhage.

The following methods of controlling bleeding should first be employed: packing, both intranasal and postnasal, vitamin K intravenously or intramuscularly, whole blood, plasma, electrolytes intravenously, elevation of the head, cold compresses and sedatives. When bleeding persists, despite these efforts, ligation of the external carotid artery may well prove to be a lifesaving measure. It is achieved with ease, involves very little hazard and the result is most gratifying.

REPORTS OF CASES

Case 1. Mr. E. H., a vigorous male, aged 40, underwent a submucous resection on February 21, 1951. History and physical examination were irrelevant. Blood pressure 122/84, coagulation time, blood picture and urinalysis showed nothing abnormal.

On the seventh postoperative night he was awakened by nasal bleeding. His nose was packed and he was given supportive treatment. Packing was removed on the third day of his re-admission and he was discharged on the fifth day. He was re-admitted six days later, having bled intermittently for three days in spite of packing and general supportive treatment administered by his local physician. Upon his third admission he was taken to the operating room and all of the packing removed. Rather brisk bleeding was encountered in the left posterior nasal cavity. A snug postnasal pack was introduced bilaterally. Both nasal cavities were packed firmly and postnasal packing was secured to a gauze roll at the anterior nares. He was transfused with whole blood, 550 c.c. He continued to bleed through this pack and went into shock. His blood pressure could not be obtained and his veins collapsed. He was again taken to the operating room, in bed, where he remained while the external carotid artery on the left side was ligated whereupon bleeding was immediately controlled. Packing was removed the fol-

lowing morning and he has not bled to date, postoperative, six weeks.

Case 2. Mr. J. E., aged 32, was sent in by his family doctor on March 21, 1951, after having bled at frequent intervals for three days despite packing and usual supportive treatment. On arrival he was quite pale, weak and frightened. His history was significant in that he had been partaking of considerable alcoholic beverages for the past five years and had been on an inadequate diet during this time. The laboratory findings were negative except for the expected low hemoglobin and red count. This patient was also repacked carefully and given supportive treatment mentioned above. He, too, continued to bleed through the pack. Ligation of the carotid artery was elected in his case before profound shock set in. Pack was removed the following day and when last seen, ten days after the operation, he had no recurrence of the bleeding.

Discussion

Indication. Ligation of the external carotid artery is indicated:

1. In nasal bleeding when conservative methods have failed to control the hemorrhage;
2. As a prophylactic measure when radical surgery or irradiation is anticipated.

Technic. Under either local or general anesthesia, as indicated, the incision is made along the anterior belly of the sternocleidomastoid muscle at the level of the superior aspect of the thyroid cartilage. The muscle is retracted and the carotid sheath exposed by blunt dissection. Palpation of the pulsating carotid artery easily identifies it through its sheath; the sheath is entered with caution, the jugular vein is carefully isolated and retracted, thus exposing the carotid and the vagus nerve. After exposing the bifurcation of the common carotid, the external carotid is easily distinguished by the superior thyroid artery, which is its first branch in the neck. The internal carotid does not give off any branches in the neck. The external carotid is ligated with silver wire when permanent ligation is desired. To control bleeding for a shorter time, it may be ligated with braid silk or even heavy chromic gut.

Hazards. 1. Venous bleeding must be kept in mind. Cutting or tearing of the large, delicate veins may result in air emboli

due to the sucking action of the respiratory movements.

2. The vagus nerve must be handled with caution.

3. Sharp dissection is to be avoided after the skin incision is made. Tissues should be separated with the fingers, the knife handle, or by the spreading action of dissecting scissors or Kelly clamp.

Conclusion

Ligation of one or both external carotid arteries may be resorted to in extreme cases either to combat shock from trauma or operation or as a prophylactic measure to avoid anticipated bleeding in radical surgery or irradiation. The procedure is relatively easy and safe; the result is assured.

Ponce de Leon Eye and Ear Infirmary, 144 Ponce de Leon Avenue, N. E., Atlanta.

OVERCROWDED CLASSES AND "PERFECT ATTENDANCE RECORDS" CALLED HAZARDS IN GUARDING AGAINST RHEUMATIC FEVER

American Heart Association Booklet for Teachers Tells What to Do About Children with Heart Disease.

Overcrowded classes in elementary schools and insistence on perfect attendance records are seen as hazards in guarding against rheumatic fever and rheumatic heart disease, which have been called "childhood's greatest enemy." Alertness by the teacher to early danger signals of poor health and understanding guidance of child and parent are recommended in a new booklet, "What the Classroom Teacher should Know—and Do—About Children with Heart Disease," published by the American Heart Association and its affiliates.

Crowded classrooms are listed among the bad environmental conditions that can lead to a "strep" infection, the "time bomb" that may be a forerunner of rheumatic fever. Although rheumatic fever itself is not catching, the preceding "strep" infection is. Teachers are therefore warned that "preventing strep infections from spreading in the classroom may prevent some cases of rheumatic fever."

With many thousands of cases of rheumatic fever or rheumatic or congenital heart disease each year, and with rheumatic fever constituting the leading fatal disease between the ages of 5 and 19, the teacher is viewed as a valuable ally to doctor and parent in fighting this scourge of the younger generation.

"No one but a physician can diagnose rheumatic fever," the Heart Association booklet points out. "But the teacher has a unique opportunity to help in rheumatic fever control through early detection of danger signals and prompt referral to the school health service.

"There is no simple test for diagnosing rheumatic fever in its early stages. That is why teacher observation and prompt referral of the under-par child is important. . . .

"The informed teacher, aware of the so-called 'silent' phase in the development of rheumatic fever, will be particularly observant of a child about one week to a month after he has recovered from a 'cold,' or from any known 'strep' infection, such as scarlet fever."

During the acute period of rheumatic fever, which may last weeks or months, the child should NOT be in school, according to the booklet.

Rheumatic fever has a "nasty tendency" to strike again and again, with possible increasing damage to the heart. "The prime concern in the treatment of a child who has had rheumatic fever," the booklet notes, "is the prevention of a second attack."

Quoting a committee that studied the problem in New York, the booklet says. "Immediately upon the recognition of a respiratory or other infection, the rheumatic child should remain home and receive prompt medical attention. Furthermore, all children with respiratory infections should be kept from close contact with the rheumatic child. This may involve some measure of physical isolation of infected children in the classroom. . . . Less stress must be placed on perfect attendance records for all children."

Teachers are told to be on special guard against the fact that rheumatic fever tends to run in families.

Advising the teacher in classroom management of the cardiac child, the American Heart Association booklet says:

"Most cardiac children can take part in the normal activities of the regular classroom. Unless medically advised, limitations or restrictions must not be imposed. For each child there must be a plan of action based on the recommendation of the child's physician. To make a plan that will really work takes the best thinking of teachers, doctors, nurses, the school principal, and parents, with all of them working as a team. . . . Children with heart disease will be served best in schools with effective school health programs."

The booklet also points out that any chronic illness, such as rheumatic fever, often creates new social and emotional problems for the child and his family. Therefore, "The understanding teacher can help parents and child to accept realistically but without exaggeration the youngster's limitations. She can help the child feel

a part of his group even when his activities are limited. . . ."

It is also described as important for the child's mental health and vocational future that he keep up with his school work. "When the child must remain out of school over a long period, the teacher can perform an invaluable service by advising parents how to get a home teacher," the pamphlet adds.

"Educational guidance and vocational counseling should be started early so that the rheumatic and cardiac child can be directed to vocations that do not require heavy physical labor, working in damp or dusty places, or under other bad environmental conditions that may lead to "strep" infections; school teaching, for example, in overcrowded classes of elementary schools carries some hazard from this point of view. The child should be encouraged to stay on in high school and get as much

schooling as he can. This will give him a foundation for more skilled jobs."

"What the Classroom Teacher Should Know—and Do—About Children with Heart Disease," is based upon "down-to-earth suggestions" made by professional teams working on the problem. These include the Committee on Cardiac and Rheumatic Children, New York City Board of Education, and the Committee on Teacher Education of the First National Conference on Cardiovascular Diseases held in Washington last year under the joint sponsorship of the American Heart Association and the National Heart Institute of the U. S. Public Health Service. The booklet is being distributed to teachers, educational leaders, and parents. Single copies may be obtained free of charge from the American Heart Association, 1775 Broadway, New York 19, N. Y., or from local affiliated heart associations.



Indianapolis 6, Ind., April 25, 1951.

Edgar D. Shanks, M.D., Editor
Georgia State Medical Journal
Doctors Building
478 Peachtree Street, N. E.
Atlanta, Georgia.

Dear Doctor Shanks:

We are attaching a photograph taken at the time the Emory University, School of Medicine, were guests of Eli Lilly and Company on April 12, 13, and 14, 1951.

During their visit, they made a thorough inspection

of the Laboratories including the Research Laboratories, replica of the original laboratories, and the Biological Laboratories at Greenfield, Indiana, where demonstrations were made showing the production of biological products.

The thought occurs to us that you may wish to make use of this material as a news item in the Georgia State Medical Journal.

Very truly yours,

ELI LILLY AND COMPANY
A. E. Stensby, Manager
Professional Relation Department

THE JOURNALOF THE
MEDICAL ASSOCIATION OF GEORGIA875 West Peachtree Street, N. E.
Atlanta, Georgia

MAY, 1951

WE LOOK AHEAD

Now that the smoke of our recent political campaigns has cleared, you, the members of the Medical Association of Georgia, are no doubt awaiting some tangible evidence of improvement in the organization. As is customary in our American system of Democracy, your elected officials promised much. Their ability to produce will now be subjected to close scrutiny—as it must be if the Association is to continue its progress and is to effectively and efficiently function in the service of the medical profession and the physicians of Georgia.

Perhaps the most interesting — and thought provoking — comment made to me both during and after the election was, “I don’t see why you want the job,” or something similar.

I have given much serious thought to this question and to the answer. I can truthfully say that no political ambitions were involved; thus, my sincere desire to lend whatever talents I have to the objectives of organized medicine seems to be the only answer. If the medical profession is to remain free from the grasp of those who see personal gain in its control, we all must accept our responsibilities as we see them. I will continue, as I have in the past, to make myself available wherever needed for the sole purpose of furthering the interests and solving the problems of my profession.

As in our local, state and national governments, the elected officials must be the representatives of their constituents, however. This means that they must act upon

the views and desires of the members, but, to do this, the support and interest of the members is mandatory. If nothing else is accomplished, I hope to see The Medical Association of Georgia become more of an *association*, in fact, and to see the membership take an active part in its work.

How can you serve the profession which has served you so well? It was most encouraging to note the willingness on the part of many members to cooperate actively in the Association’s endeavors. Many asked merely to be told what to do, but some will, I’m afraid, plead the pressure of work when approached with a request to help. This reminds me of the query made by an insurance salesman when I told him that I was too busy to talk about life insurance.

“You’re not too busy to die, are you?” he asked.

We may be too busy to serve on committees and take part in other activities, but we will certainly pause long enough to watch when our profession is enfolded by a Government bureau.

With the enthusiastic display of interest that was evinced by many of the members, however, I’m sure your officials can map out a progressive program of action with confidence in its being carried to fruition.

Just as a doctor, supplied with his knowledge, experience, and a desire to be of service to humanity, can accomplish little without certain material necessities, your officials and employees can do little without adequate quarters and equipment. Concretely, the needs of the Association are many, but undoubtedly one of the most urgent of these, at the present, is the necessity for adequate quarters for the administrative offices. The dark, damp atmosphere of any basement room is not at all conducive to efficiency, nor is the separation of departments and personnel desirable. The increasing amount of work being done by our

Public Relations Department, and by all departments, indicates a need for more space in one unit where equipment and supplies can be used jointly.

The Fulton County Medical Society has been most cooperative in offering the use of its building, and it is hoped that the state Association's requirements can be met in such a way that will be mutually advantageous.

Your attention is directed to the new Constitution and By-Laws which has been published in booklet form and will be sent to each member in the near future. This represents several years' work, and, while not a finished product, it meets many of our needs. The committee that is responsible for the changes made will continue to function and will work to bring about other changes that are desired and to eliminate certain faults that have already put in their appearance.

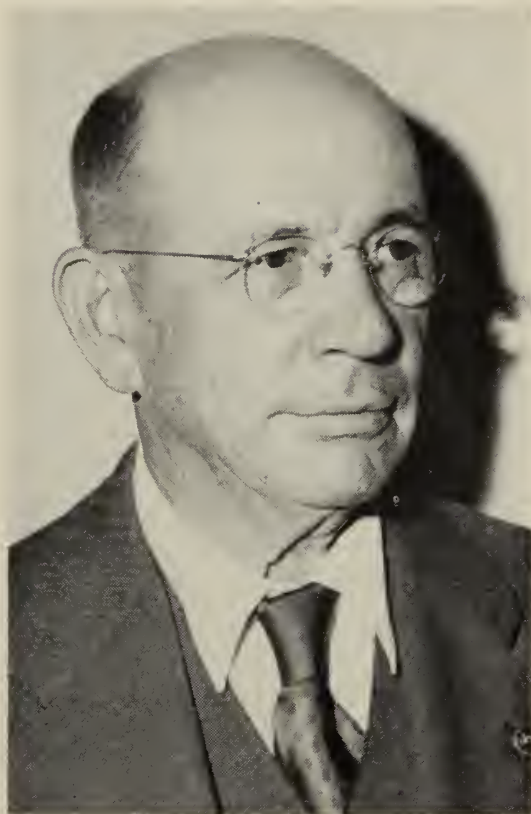
The future is before us—let's make it one of progress for The Medical Association of Georgia.

DAVID HENRY POER, M.D.

CORNELIUS FULLMER HOLTON, M.D.

It has long been the custom of the Medical Association of Georgia to elect for its President-Elect one of its distinguished members. This year was no exception to the rule: Dr. Cornelius Fullmer Holton of Savannah, long an active worker in the affairs of medicine in Georgia, was elected unanimously President-Elect. He will become President of the Association at its annual session in 1952.

The son of the late Cornelius Fitzgerald Holton and Susie Taylor Holton, formerly of Hawkinsville, Ga., Cornelius Fullmer Holton was born at Lakeland, Fla., Nov. 6, 1889. When he was ten years of age his parents relocated in Georgia, at Cordele, where



CORNELIUS FULLMER HOLTON, M.D.
Savannah
President-Elect 1951-1952

he continued his education to the end he was graduated from O'Neill High School, Cordele. Upon his graduation from High School, he soon sought other fields in which he could augment his education and decide what his life's work would be. First, he gave the study of law serious consideration, but always there was in his mind his first ambition; namely, to become a physician. With the problem decided, he soon located in Atlanta and earnestly began the long climb to a successful medical career. He was graduated from the Atlanta College of Physicians and Surgeons, now part of Emory University, in the class of 1913.

Dr. Holton continued his medical education at Grady Memorial Hospital, Atlanta. Upon completion of his work at Grady he became associated with the late Dr. James N. Ellis of Atlanta, with whom he practiced for several months before being called for

active duty with the Georgia National Guard in its 1916-17 tour of duty at the Mexican border. Early showing evidence of leadership, Dr. Holton was designated commanding officer of Field Hospital No. 1. Later he accompanied the 31st N. G. Division to France. Still later he was assigned commanding officer of 111th Camp Hospital.

Returning from overseas in 1919, and believing every man is happiest when he lives and works in an environment suitable to him, Dr. Holton opened offices for the practice of his profession in Savannah, Nov. 1, 1919. Immediately he identified himself with the professional and civic activities of his chosen city and home, as evidenced by the following: He is past president of the Georgia Medical Society (Chatham County), and was a duly elected alderman of the City of Savannah and chairman of the city's council for four years.

Dr. Holton is chief surgeon of the Central of Georgia Railway, and director of its hospital in Savannah, but also carries on an active private practice. Other hospital affiliations include staff membership at St. Joseph, Telfair and Warren A. Candler, and trusteeship at Georgia Infirmary, all located in Savannah. In addition to being a member of his local and State medical organizations, he is a member of the Southern Medical Association, American Medical Association, and Association of Railway Surgeons. He is a fellow of the Southeastern Surgical Congress, and American College of Surgeons. He was founder and first president of the Georgia Industrial Surgeons Association, and was co-founder and first president of the Georgia Chapter of the American College of Surgeons. He is medical director of the Southern States Iron Roofing Company.

He is a member of the Baptist Church, Shrine, and Ancient Order of Hibernians.

He is a member of Phi Chi Medical Fraternity. His hobbies being golf, hunting and fishing, he is a member and past president of Savannah Golf Club. Other club memberships include Oglethorpe and Savannah Yacht, both located in Savannah. Finally, he is a member of the local Rotary Club, in which he takes an active part in all its activities.

Despite Dr. Holton's busy life, which includes frequent attendance at graduate medical assemblies, he finds some time to be with his fine family. Mrs. Holton, the former Miss Mary Gray of New York City and Millen, Ga., "keeps the home fires burning" and is at all times a gracious hostess to the many persons who visit the Holton home in Georgia's oldest city—Savannah. Dr. and Mrs. Holton's two children—Mary, aged 18 and a student at the University of Georgia, and Robert, aged 21, an aviation cadet presently at home—add charm to the family life of the Holtons.

Medically, politically, economically, and otherwise, the medical profession of this and other countries is always busily engaged in solving problems for the benefit of all mankind. The Medical Association of Georgia, now 102 years old, assumes its share of responsibility in this everlasting program. Dr. Holton, as President-Elect of the Association, is qualified to fill the position to which he was elected, but he will need the cooperation of each member of this Association. Let us resolve now to give him that unflinching help.

—E. D. S.

IF YOUR A.M.A. JOURNAL IS MISSING

Recently the Executive Office of the Society has received a number of telephone calls from members asking the question, "I haven't been receiving the J.A.M.A. for the last few weeks.

Reprinted from New York Medicine, official publication of the Medical Society of the County of New York, March 20, 1951.

I sent in my check for \$25 for A.M.A. dues on such-and-such a date. What has happened?"

Investigation reveals that these calls usually are from members who did not pay their 1950 A.M.A. dues by the deadline date of December 31, 1950, and who have since sent in their checks for 1950 on—say—January 15, 1951.

What has happened is quite simple. When the 1950 dues were not paid by the end of the year the doctor entered the category of delinquent membership in the A.M.A. His name was removed from the roster of members and his name was removed from the list of those who receive the Journal of the A.M.A.

Such delinquent members will not be entered on the circulation list of the Journal of the A.M.A. until they have been reinstated to full membership. This means they must pay BOTH their 1950 and 1951 dues. If they have now paid their 1950 dues (after Jan. 1, 1951) they must also pay the 1951 dues before they enter status of member in good standing. Until then they will not receive the Journal.

Word direct from the A.M.A. is that members who paid their 1950 dues on time (before the end of the year 1950) are in good standing and have until the end of 1951 to pay their 1951 dues. They are considered as 'good circulation risks' and will continue to receive the Journal during 1951 even if they cannot pay their 1951 A.M.A. dues until later this year.

BUT members who did not pay their 1950 dues on time are now delinquent. They are not considered good circulation risks and the Journal will not be sent to them until they enjoy full reinstatement by paying both 1950 and 1951 dues.

It was explained in the circular which accompanied the bills for A.M.A. dues that both 1950 and 1951 dues must be paid. The penalty for those who did not read this, did not believe it, or did not act upon this advice is the penalty of not receiving the Journal of the A.M.A.

When a member pays his full dues and is reinstated in the A.M.A. his subscription to the Journal will start again. And the reinstated member can write directly to the Office of the J.A.M.A. and ask for back copies that he has missed.

We are informed that the Journal printed a number of extra copies of the early issues of 1951 to cover just this possibility. But the extra supply is limited and there can be no guarantee that the supply will not be exhausted.

To repeat the main point:

A.M.A. members who paid their 1950 dues during 1950 have no need to worry. Their J.A.M.A. will keep coming to them throughout the year. But they must pay their 1951 A.M.A. dues during 1951, quite naturally.

Members who have not paid their 1950

A.M.A. dues until after January 1, 1951, are temporarily NOT receiving the Journal and this is one of the penalties they pay for being delinquent.

Already a few calls have come from delinquent members who have now paid their 1950 and 1951 A.M.A. dues and cannot understand why they do not immediately receive the A.M.A. Journal the following week after they write out their checks. To these physicians it may be of interest to know something of the process of reinstatement.

For example, thousands of checks from members come to the County Society for payment of A.M.A. dues. After opening the envelopes and sorting out the checks, the proper amounts must be entered upon individual treasurer's cards for the permanent records. Lists of names of members paying dues must be arranged in alphabetical order for the auditors. Each check must be stamped for deposit, and deposit slips filled out and rechecked again. The money for A.M.A. dues thus enters the bank to the account of the County Society.

All these operations, including still others, are simultaneously going on to record the payments for County and State dues which are handled separately.

Following such activity at the level of the county society alphabetized lists of members who have paid their A.M.A. dues are sent to the Medical Society of the State of New York together with a check to cover payment of such dues. The State Society, in its turn, must enter the information on its cards, prepare audit lists, make deposits and maintain its own set of records.

Next the State Society sends to the A.M.A. lists of members who have paid their A.M.A. dues and sends covering checks for each such list.

In its turn the A.M.A. must enter all information on its own cards and—along the way—notifies the A.M.A. Journal that member X, for example, is now in good standing. If member X's name has been removed from the mailing list of the J.A.M.A., because he was delinquent, a new addressograph plate must be prepared with his name and address so that labels can be printed to mail his magazine. Since these labels are prepared an issue or two ahead of mailing it thus takes several weeks to start the machinery flowing again at the Journal office.

All these steps—at the county level, at the state level, and at the national level—provide an explanation of why it is impossible to expect that as soon as a check is mailed to the N. Y. County Medical Society the Journal of the A.M.A. will arrive the next week.

THE MEDICAL ASSOCIATION OF GEORGIA

875 West Peachtree Street, N. E.

ATLANTA, GEORGIA

OFFICERS FOR 1951-52

President—W. F. Reavis, Waycross
 President-Elect—C. F. Holton, Savannah
 First Vice-President—Robert C. McGahee, Augusta
 Second Vice-President—H. Ansley Seaman, Waycross
 Secretary-Treasurer—David Henry Poer, Atlanta

DELEGATES TO THE A.M.A.

Terms expire December 31, 1952:

B. H. Minchew, Waycross, and Eustace A. Allen,
 Atlanta. Alternates: William R. Dancy, Savannah,
 and Carter Smith, Atlanta.

Terms expire December 31, 1953:

C. H. Richardson, Sr., Macon. Alternate, C. L. Ayers,
 Toccoa.

EXECUTIVE COMMITTEE

W. F. Reavis, President, Waycross
 David Henry Poer, Secretary-Treasurer, Atlanta
 W. G. Elliott, Chairman of Council, Cuthbert
 D. Lloyd Wood, Member of Council, Dalton

COUNCILORS

District	Councilor	Term Expires
1—	Lee Howard, Savannah	1952 Session
2—	C. K. Wall, Thomasville	1952 Session
3—	W. G. Elliott, <i>Chairman</i> , Cuthbert	1952 Session
4—	J. W. Chambers, LaGrange	1953 Session
5—	Marion C. Pruitt, Atlanta	1953 Session
6—	H. D. Allen, Jr., Milledgeville	1953 Session
7—	D. Lloyd Wood, Dalton	1953 Session
8—	Sage Harper, <i>Vice-Chairman</i> , Douglas	1953 Session
9—	W. Bruce Schaefer, Toccoa	1954 Session
10—	H. L. Cheeves, Union Point	1954 Session

VICE-COUNCILORS

District	Vice-Councilor	Term Expires
1—	Chas. T. Brown, Guyton	1952 Session
2—	C. H. Watt, Thomasville	1952 Session
3—	Guy J. Dillard, Columbus	1952 Session
4—	Clarence B. Palmer, Covington	1952 Session
5—	John W. Turner, Atlanta	1953 Session
6—	H. G. Weaver, Macon	1953 Session
7—	M. M. Hagood, Marietta	1953 Session
8—	J. A. Leaphart, Jesup	1953 Session
9—	Charles R. Andrews, Jr., Canton	1954 Session
10—	J. Victor Roule, Augusta	1954 Session

Honorary Advisory Board

W. S. Goldsmith	President, 1915-1916
Eugene E. Murphey	President, 1917-1918
J. W. Palmer	President, 1918-1919
J. W. Daniel	President, 1923-1924
Frank K. Boland	President, 1925-1926
C. K. Sharp	President, 1928-1929
Wm. R. Dancy	President, 1929-1930
M. M. Head	President, 1932-1933
C. H. Richardson	President, 1933-1934
Clarence L. Ayers	President, 1934-1935
James E. Paullin	President, 1935-1936
B. H. Minchew	President, 1936-1937
Grady N. Coker	President, 1938-1939
J. C. Patterson	President, 1940-1941
Allen H. Bunce	President, 1941-1942
James A. Redfearn	President, 1942-1943
W. A. Selman	President, 1943-1944
Cleveland Thompson	President, 1944-1946
Ralph H. Chaney	President, 1946-1947
Steve P. Kenyon	President, 1947-1948
Edgar H. Greene	President, 1948-1949
Enoch Callaway	President, 1949-1950
A. M. Phillips	President, 1950-1951

1951-1952 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1—	A. Bird Daniel, Statesboro	William H. Fulmer, Savannah	
2—	C. K. Sharp, Arlington	Frank A. Little, Thomasville	
3—	Carl P. Savage, Montezuma	T. Schley Gatewood, Americus	Americus, June 21, 1951
4—	H. Hilt Hammett, Jr., LaGrange	James M. Bryant, Jr., Newnan	
5—	Carter Smith, Atlanta	L. Minor Blackford, Atlanta	
6—	Leon D. Porch, Macon	C. H. Richardson, Jr., Macon	Dublin, June 28, 1951
7—	S. M. Howell, Cartersville	S. B. Kitchens, LaFayette	
8—	J. B. Avera, Brunswick	James L. Compbell, Jr., Valdosta	
9—	E. A. Roper, Jasper	Hartwell Joiner, Gainesville	
10—	M. C. Adair, Washington	A. W. Simpson, Jr., Washington	

(Note to Secretaries: Send in reports of meetings promptly. Also corrections and changes in above list).

WOMAN'S AUXILIARY OFFICERS 1951-1952

President—Mrs. J. R. S. Mays, Macon
 President-Elect—Mrs. Ralph Fowler, Marietta
 First Vice-President—Mrs. T. A. Peterson, Savannah
 Second Vice-President—Mrs. R. C. McGahee, Augusta
 Third Vice-President—Mrs. Leo Smith, Waycross
 Recording Secretary—Mrs. Virgil Williams, Griffin
 Treasurer—Mrs. M. T. Edgerton, Atlanta
 Historian—Mrs. Ralph McCord, Rome
 Corresponding Secretary—Mrs. Rhea Richardson, Macon
 Parliamentarian—Mrs. Ralph Chaney, Augusta

NEXT ANNUAL SESSION
OF THE
MEDICAL ASSOCIATION OF GEORGIA
ATLANTA BILTMORE HOTEL
ATLANTA, GEORGIA
DATES: May 11, 12, 13, 14, 1952

THE MEDICAL ASSOCIATION OF GEORGIA COMMITTEES 1951-1952

NOTE: Members of Standing Committees are ordinarily appointed for a period of three years and the senior member usually serves as chairman. Members of Special Committees serve until the time of the next Annual Session unless otherwise provided for.

STANDING COMMITTEES

SCIENTIFIC WORK—Richard Torpin, chairman, Augusta; Thomas L. Ross, Jr., vice-chairman, Macon; H. Ansley Seaman, Waycross; W. F. Reavis, Waycross; David Henry Poer, Atlanta.

PUBLIC POLICY AND LEGISLATION—Spencer A. Kirkland, chairman, Atlanta; C. C. Aven, Atlanta; Jack C. Norris, Atlanta. (Sub-committee composed of one member nominated by each County and District Society).

MEDICAL EDUCATION AND HOSPITALS—G. Lombard Kelly, chairman, Augusta; R. Hugh Wood, Atlanta; C. H. Richardson, Sr., Macon.

MEDICAL DEFENSE—Marion C. Pruitt, Chairman, Atlanta; B. H. Minchew, Waycross; Marcus Mashburn, Cumming; W. G. Elliott, Cuthbert; David Henry Poer, Atlanta.

PROFESSIONAL CONDUCT—Ralph H. Chaney, chairman, Augusta; Steve P. Kenyon, Dawson; Edgar H. Greene, Atlanta; Enoch Callaway, LaGrange; A. M. Phillips, Macon.

HISTORY AND VITAL STATISTICS—J. Calvin Weaver, chairman, Atlanta; Frank K. Boland, Atlanta; Ernest F. Wahl, Thomasville.

PUBLIC HEALTH—J. C. Brim, chairman, Pelham; C. L. Ayers, Toccoa; B. Hollis Hand, LaGrange. (Sub-committee composed of one member nominated by each County and District Society).

SPECIAL COMMITTEES

PUBLIC RELATIONS—Stephen T. Brown, chairman, Atlanta; C. C. Aven, vice-chairman, Atlanta; W. G. Elliott, Cuthbert; W. F. Reavis, Waycross; David Henry Poer, Atlanta; D. Lloyd Wood, Dalton.

WOMAN'S AUXILIARY—Ralph H. Chaney, chairman, Augusta; Steve P. Kenyon, Dawson; Edgar H. Greene, Atlanta; Enoch Callaway, LaGrange; A. M. Phillips, Macon.

INSURANCE AND ECONOMICS—W. S. Dorough, chairman, Atlanta; John L. Elliott, vice-chairman, Savannah; Kenneth D. Grace, LaGrange; W. L. Pomeroy, Waycross; D. Lloyd Wood, Dalton.

ORTHOPEDICS—J. Hiram Kite, chairman, Atlanta; Peter B. Wright, vice-chairman, Augusta; Thomas P. Goodwyn, Atlanta; F. Bert Brown, Savannah; John I. Hall, Macon; W. A. Newman, Macon; H. Walker Jernigan; C. E. Irwin, Warm Springs; Lawson Thornton, Atlanta; C. G. Henry, Augusta.

STUDENT LOAN FUND—Mrs. Shelley C. Davis, chairman, Atlanta; G. Lombard Kelly, Augusta; R. Hugh Wood, Atlanta.

AWARDS—C. H. Richardson, Sr., chairman, Macon; Mason I. Lowance, Atlanta; William R. Dancy, Savannah.

CONSTITUTION AND BY-LAWS—Enoch Callaway, chairman, LaGrange; W. F. Reavis, Waycross; Allen H. Bunce, Atlanta; A. M. Phillips, Macon; John A. Dunaway, Attorney for the Association, Atlanta; David Henry Poer, secretary-treasurer, Atlanta.

LIAISON COMMITTEE GEORGIA STATE MEDICAL ASSOCIATION (Negro)—J. F. Hanson, chairman, Macon; W. E. Storey, Columbus; Lee H. Battle, Jr., Rome; E. Van Buren, Atlanta; H. H. Allen, Decatur.

CANCER—J. Elliott Scarborough, chairman, Emory University; Everett L. Bishop, Atlanta; Robert C. Pendergrass, Americus; Thomas Harrold, Macon; Enoch Callaway, LaGrange; Lee Howard, Savannah; W. F. Jenkins, Columbus; Hoke Wammoth, Augusta; D. M. Bradley, Waycross; John Funke, Atlanta; J. J. Collins, Thomasville; Max Mass, Macon; John L. Barner, Athens; Charles R. Andrews, Jr., Canton.

LIAISON COMMITTEE OF 53 CONSTITUENT STATE MEDICAL ASSOCIATIONS TO COORDINATE EDUCATIONAL PROGRAM OF THE A.M.A.—Jack C. Norris, Atlanta.

REVISION OF PHARMACOPEIA OF U. S.—Allen H. Bunce, chairman (1960), Atlanta; C. C. Aven (1960), Atlanta; Hal M. Davison (1960), Atlanta.

PEDIATRICS—Philip A. Mulherin, chairman, Augusta; Don F. Cathcart, vice-chairman, Atlanta; Frank Schley, Columbus; Edwin R. Watson, Macon; M. M. McCord, Rome; Howard J. Morrison, Savannah; W. Charles Boswell, Macon; A. M. Johnson, Valdosta; C. M. Massey, Waycross.

MATERNAL CARE—H. F. Sharpley, Jr., chairman, Savannah; E. D. Colvin, vice-chairman, Atlanta; Guy V. Rice, Augusta; John R. McCain, Atlanta; Hugh J. Bickstaff, Columbus.

FRATERNAL DELEGATES TO OTHER STATES

ALABAMA—Elwyn V. Patrick, Carrollton; Enoch Callaway, LaGrange; Willis P. Jordan, Jr., Columbus.

FLORIDA—J. B. Avera, Brunswick; Steve P. Kenyon, Dawson; J. F. Mixson, Jr., Valdosta.

NORTH CAROLINA—Marion A. Hubert, Athens; R. Lee Rogers, Gainesville; W. Bruce Schaefer, Toccoa.

SOUTH CAROLINA—Wiley S. Flanagan, Augusta; F. Bert Brown, Savannah; Tyrus R. Cobb, Jr., Dublin.

TENNESSEE—Lee H. Battle, Jr., Rome; S. E. Andrew, Waycross; Truman W. Whitfield, Dalton.

STATE BOARD OF HEALTH*—First District: James M. Byne, Jr., Waynesboro, Sept. 1, 1951; Second District: C. K. Sharp, Arlington, Sept. 1, 1951; Third District: R. C. Montgomery, Butler, Sept. 1, 1954; Fourth District: M. M. Head, Zebulon, Sept. 1, 1955; Fifth District: Spencer A. Kirkland, Atlanta, Sept. 1, 1954; Sixth District: Walter Bramblett, Jr., Forsyth, Sept. 1, 1956; Seventh District: Fred H. Simonton, Chickamauga, Sept. 1, 1956; Eighth District: C. J. Maloy, McRae, Sept. 1, 1956; Ninth District: R. Lee Rogers, Gainesville, Sept. 1, 1951; Tenth District: Thos. W. Goodwin, Augusta, Sept. 1, 1955.

STATE OF GEORGIA AT LARGE—GEORGIA DENTAL ASSOCIATION**—J. M. Hawley, Columbus, Sept. 1, 1952; J. G. Williams, Atlanta, Sept. 1, 1952.

GEORGIA PHARMACEUTICAL ASSOCIATION—Preston Sumner, East Point, Sept. 1, 1953; A. T. McRae, Douglas, Sept. 1, 1956.

STATE BOARD OF MEDICAL EXAMINERS—Edgar H. Greene, Atlanta; J. W. Palmer, Ailey; Steve P. Kenyon, Dawson; Grady N. Coker, Canton; R. H. McDonald, Newnan; Phil E. Roberson, Albany; Fred J. Coleman, Dublin; Alexander B. Russell, Winder; Rufus A. Askew, Atlanta; W. H. Powell, Hazlehurst.

BETTER HEALTH COUNCIL OF GEORGIA—Mrs. Shelley Davis, chairman, Atlanta; Mrs. Fred Knight, vice-chairman, Cartersville; Drs. W. F. Reavis, Waycross; Tully Bialock, Edgar H. Greene, Christopher McLoughlin, T. F. Sellers, R. Hugh Wood, all of Atlanta; Enoch Callaway, LaGrange; James A. Johnson, Jr., Manchester; G. Lombard Kelly, Augusta; Steve P. Kenyon, Dawson; Miss Dana Hudson, R.N.; Rev. Emmett McNabb, J. Ross Tucker, D.D.S.; Rev. Herman Turner, H. R. Yandle, all of Atlanta; Mrs. R. K. Winston, Tifton; Dr. H. Stewart Wooten, Milledgeville. Regional Chairmen: J. Phil Campbell, Watkinsville; H. B. Forester, Dahlonega; Mrs. Lester Harbin, Rome; Mrs. C. E. Powell, Swainsboro; Mrs. Paul Russell, Albany; Mrs. Bruce Schaefer, Toccoa; E. J. Willis, Bainbridge; T. D. Wooten, Lumber City.

*Nominated by their respective district medical societies and appointed for six-year terms.

**Nominated by their respective associations.

KEEP THIS PAGE FOR REFERENCE

MEDICAL ADVISORY COMMITTEES

MEDICAL ADVISORY COMMITTEE TO THE SELECTIVE SERVICE SYSTEM OF THE STATE OF GEORGIA—Carter Smith, M.D., chairman, Atlanta; A. O. Lynch, M.D., vice-chairman, Atlanta; T. F. Sellers, M.D., Atlanta; L. Minor Blackford, M.D., Atlanta; David Henry Poer, M.D., Atlanta; Cyrus W. Strickler, Jr., M.D., Atlanta; Steve A. Garrett, D.D.S., Atlanta; Charles C. Rife, D.V.M., Atlanta.

PARTIAL LIST OF MILITARY AFFAIRS COMMITTEES
(Appointed by Each County Medical Society to Advise the State Committee)

APPLEY COUNTY—H. C. McCrackin, chairman, Baxley; M. D. Shairman, Baxley; J. B. Brown, Jr., Baxley; J. A. Bedingfield, Baxley.

BALDWIN COUNTY—T. G. Peacock, chairman; Milledgeville; H. Dawson Allen, Milledgeville; O. C. Woods, Milledgeville.

BIBB COUNTY—W. R. Golsan, chairman, Macon; Chas. N. Wasden, Macon; John I. Hall, Macon; Harold C. Atkinson, Macon; Thomas L. Ross, Jr., Macon.

BULLOCH-CANDLER-EVANS COUNTIES—A. Bird Daniel, chairman, Statesboro; Albert M. Deal, Statesboro; Louie H. Griffin, Claxton; John Mooney, Jr., Statesboro.

CARROLL-DOUGLAS-HARALSON COUNTIES — Steve Worthy, chairman, Carrollton; R. L. Berry, Villa Rica; R. E. Hamilton, Douglasville; W. P. Downey, Tallapoosa.

GEORGIA MEDICAL SOCIETY (Chatham County)—L. B. Dunn, chairman, Savannah; T. A. McGolderick, Jr., Savannah; J. C. Metts, Savannah; W. L. Osteen, Savannah; Jacob Rubin, Savannah.

CLARKE-MADISON-OCONEE COUNTIES—H. B. Harris, chairman, Athens; M. A. Hubert, Athens; Clark H. Bryant, Comer; W. Harvey Cabaniss, Athens.

CLAYTON-FAYETTE COUNTIES—T. J. Bussey, chairman, Fayetteville; J. L. Robak, Jonesboro; J. R. Wallis, Lovejoy; Y. R. Coleman, Jonesboro.

COBB COUNTY—E. A. Musarra, chairman, Marietta; Alfred O. Colquitt, Jr., Marietta; Bruce D. Burleigh, Marietta.

COFFEE COUNTY—Sage Harper, chairman, Douglas; Dan A. Jardine, Douglas; Horace G. Joiner, Douglas.

COLQUITT COUNTY—P. D. Conger, chairman, Moultrie; Robert E. Stegall, Moultrie; James R. Paulk, Moultrie, J. B. Woodall, Moultrie.

COWETA COUNTY—G. P. Kinnard, chairman, Newnan; H. D. Meaders, Newnan; J. H. Arnold, Newnan.

CRISP COUNTY—C. E. McArthur, chairman, Cordele; L. O. Wootten, Cordele; A. J. Whelchel, Cordele.

DECATUR-SEMINOLE COUNTIES—H. B. Jenkins, chairman, Donalsonville; H. B. Baxley, Donalsonville; John P. Tucker, Bainbridge; Chas. G. Bellville, Bainbridge.

DOUGHERTY COUNTY—Frank K. Neill, chairman, Albany; Paul T. Russell, Albany; Alfred E. James, Albany; Chas. S. McCall, Jr., Albany; Frank McKemie, Albany.

FLOYD COUNTY—Ralph Johnson, chairman, Rome; Lee H. Battle, Jr., Rome; Warren Gilbert, Rome; Ed Bosworth, Rome.

FULTON COUNTY—Chas. E. Dowman, chairman, Atlanta; A. O. Lynch, co-chairman, Atlanta; Charles Eberhart, Atlanta; Wm. R. Crowe, Atlanta; Bernard Wolff, Atlanta; Jos. S. Skobba, Atlanta; E. M. Dunstan, Atlanta.

GLYNN COUNTY—I. G. Towson, chairman, Sea Island; S. P. McDaniel, Brunswick; C. A. Wilson, Jr., Brunswick; Frank B. Mitchell, Jr., Brunswick.

HALL COUNTY—C. W. Whitworth, chairman, Gainesville; Raleigh Garner, Gainesville; W. C. McCarver, Jr., Gainesville; Herbert Valentine, Jr., Gainesville.

HANCOCK COUNTY—H. L. Earl, chairman, Sparta; C. S. Jernigan, Sparta; E. H. Hutchings, Sparta.

HOUSTON-PEACH COUNTIES—A. Smoak Marshall, chairman, Perry; A. G. Hendrick, Perry; H. E. Weems, Jr., Perry.

JACKSON-BARROW COUNTIES—W. T. Randolph, chairman, Winder; C. B. Lord, Jefferson; L. R. Bryson, Jefferson; A. A. Rogers, Sr., Commerce.

MITCHELL COUNTY—M. W. Williams, chairman, Camilla; C. L. Howard, Pelham; E. M. Walker, Pelham.

MONROE COUNTY—George H. Alexander, chairman, Forsyth; A. W. Bramblett, Jr., Forsyth.

MORGAN COUNTY — J. H. Nicholson, Madison; E. O. White, Madison; C. H. Dickens, Madison; W. C. McGearry, Madison.

MUSCOGEE COUNTY—John L. Stapleton, chairman, Columbus; George Schuessler, Columbus; G. M. Hutto, Columbus; Dave Berman, Columbus; Luther H. Wolff, Columbus.

OCMULGEE MEDICAL SOCIETY (BLECKLEY-DODGE-PULASKI COUNTIES)—Frank P. Holder, chairman, Eastman; A. S. Batts, Hawkinsville; Richard L. Smith, Cochran.

RANDOLPH-TERRELL COUNTIES — Ernest F. Daniel, chairman, Dawson; Robert B. Martin, III, Cuthbert; Walter D. Martin, Dawson.

RICHMOND COUNTY—C. G. Henry, chairman, Augusta; V. P. Sydenstricker, Augusta; J. H. Sherman, Augusta; W. J. Williams, Augusta; J. D. Gray, Augusta; T. W. Goodwin, Augusta.

STEPHENS COUNTY—C. L. Ayers, chairman, Toccoa; J. E. D. Isbell, Toccoa; E. F. Chaffin, Toccoa.

SUMTER COUNTY—R. C. Pendergrass, chairman, Americus; H. A. Smith, Americus; A. C. Primrose, Americus; J. H. Robinson, III, Americus; Frank A. Wilson, III, Leslie.

TATNALL COUNTY—A. G. Pinkston, Jr., chairman, Glennville; A. C. Colson, Glennville; L. V. Strickland, Cobbtown.

TELFAIR COUNTY—F. A. Smith, Jr., chairman, McRae; F. R. Mann, Jr., McRae.

THOMAS COUNTY — T. Allen Futch, Jr., chairman, Thomasville; George R. Dillinger, Thomasville; John B. Morton, Thomasville; J. I. Palmer, Thomasville; Kirk Shepard, Thomasville.

TROUP COUNTY—B. Hollis Hand, chairman, LaGrange; J. W. Chambers, LaGrange; C. T. Cowart, LaGrange.

UPSON COUNTY—D. L. Head, Jr., chairman, Thomaston; R. J. Mincey, Jr., Thomaston; W. J. Gower, Thomaston; W. P. Woodall, Thomaston; H. D. Tyler, Thomaston.

WALKER-CATOOSA-DADE COUNTIES—H. F. Shields, chairman, Chickamauga; Howard C. Derrick, Jr., LaFayette; T. A. Cochran, Ringgold.

WALTON COUNTY—Ernest Thompson, chairman, Monroe; Chas. S. Floyd, Loganville; Philip R. Stewart, Monroe.

WARE COUNTY—H. Ansley Seaman, chairman, Waycross; W. L. Pomeroy, Waycross; T. J. Ferrell, Waycross; B. H. Minchew, Waycross; A. M. Knight, Jr., Waycross.

WHITFIELD COUNTY—G. L. Broadrick, chairman, Dalton; H. L. Ewing, Dalton; Trammell Starr, Dalton.

WILKES COUNTY—Morgan C. Adair, chairman, Washington; A. D. Duggan, Washington; T. W. Middlebrooks, Union Point; A. G. LeRoy, Thomson.

WORTH COUNTY—J. L. Tracy, chairman, Sylvester; H. G. Davis, Jr., Sylvester.

PR NEWS LETTER

PUBLIC RELATIONS DEPT., MEDICAL ASSOCIATION OF GEORGIA, 875 W. PEACHTREE N. E., ATLANTA, GA.

Volume I, No. 6
May 1951

Dear Doctor;

The first claim to be filed by a person insured under *The Georgia Plan* has been happily settled. Mr. Fred Shue, a resident of College Park and a machinist with the Seaboard Airline Railroad, suffered a broken leg, fractured ribs, and other injuries in an automobile accident on April 19, just a few days after his insurance agent had put his "Georgia Plan" policy into effect.

The accident occurred near Marietta, Georgia and Mr. Shue was taken to the hospital there for emergency treatment then sent to his doctor in College Park. Fortunately, Mr. Shue was eligible for the full coverage benefit of the Plan, (having an income of less than \$3600 a year) and both doctors were participants in the Plan. Thus, Mr. Shue had no doctor bill to worry about. and both physicians, received payment for their services as soon as they submitted their bills.

A CHICK COME HOME TO ROOST

The final curtain has been lowered on a little drama that took place recently. but there probably will be muttering in the streets for some time to come.

On the President's Page of the March 31 issue of the JAMA, reference was made to the following portentous statement contained in a pamphlet distributed by the Federal Security Administrator's office:

"SOCIAL SECURITY AND PUBLIC ASSISTANCE PROGRAMS ARE A BASIC ESSENTIAL FOR ATTAINMENT OF THE SOCIALIZED STATE ENVISAGED IN A DEMOCRATIC IDEOLOGY, A WAY OF LIFE WHICH SO FAR HAS BEEN REALIZED ONLY IN SLIGHT MEASURE."

Immediately, with the bluster that only a Washington bureaucrat can affect, Oscar Ewing wired the editor of the JAMA thusly: "ELEMENTARY CHECK WOULD HAVE REVEALED THAT PAMPHLET WAS WRITTEN AND ISSUED IN 1945, SOME TWO YEARS BEFORE I BECAME FEDERAL SECURITY ADMINISTRATOR. CHECKING WOULD ALSO HAVE REVEALED THAT THIS PAMPHLET IS NOT BEING CURRENTLY DISTRIBUTED BY FEDERAL SECURITY AGENCY, AND HAS NEVER HAD REMOTEST AUTHORITY AS DIRECTIVE."

In answer, Dr. Elmer L. Henderson, president of the AMA, politely informed Mr. Ewing of the facts concerning the pamphlet:

"THE PAMPHLET IN QUESTION WAS REPRINTED FOR DISTRIBUTION BY YOUR OFFICE IN 1949, WHEN THE PUBLIC RECORD INDICATES YOU WERE IN CHARGE OF THE FEDERAL SECURITY AGENCY, ITS PUBLICATIONS AND ITS DIRECTIVES TO EMPLOYEES. FIVE COPIES WERE RECEIVED IN THE MAIL HERE LAST WEEK, WHICH INDICATES CERTAIN CURRENCY STILL. THESE ALL CARRY THE IMPRINT,

'GOVERNMENT PRINTING OFFICE, 1949.' THE FACT THAT THE REPORT WAS FIRST PRINTED IN 1945 WOULD NOT SEEM TO ALTER THE FURTHER FACT THAT YOU APPARENTLY HAVE THOUGHT WELL ENOUGH OF IT TO HAVE IT REPRINTED IN 1949."

A few days later, Ewing ordered the printing to be stopped and all copies destroyed. A good fumigation seems to be in order, too; because the smell lingers on.

AS YE SOW, SO SHALL YE REAP

In a recent letter from the AMA National Education Campaign directors, the statement was made that "... a year or two ago, FSA Administrator Oscar Ewing was openly contemptuous of American medicine's ability to defend itself against bureaucratic attack." Recent press dispatches, however, are "eloquently significant of the job doctors have done in meeting and defeating their adversaries before the bar of public opinion," it was pointed out. Enclosed with the letter were reprints of editorials from the *Chicago Herald-American*, and the *Chicago Daily Tribune*. Reporting on a senator's speech, the *Herald-American* said, in part:

"Sen. Butler of Maryland . . . has urged that the American people 'examine and reexamine' the multitudinous government controls the Truman Administration is eagerly imposing in the name of national emergency.

"Sen. Butler's advice is sound and the American people should heed it, because the swarming Socialists of the Truman Administration obviously are not content to impose only such regulations and restraints as are necessary to the country's safety. **THEY ARE ALSO TRYING TO IMPOSE CONTROLS DESIGNED TO TRANSFORM AMERICA INTO A SOCIALIST STATE.**"

Further on in the editorial, the attempt, by the Administration, to write Socialized Medicine into the new draft bill was referred to.

The Chicago Daily Tribune, dealing with the reduction of Oscar Ewing's funds by the House of Representatives, said, "The House today voted restrictions against propaganda activities of Federal Security Administrator Oscar Ewing in behalf of socialized medicine." His travel and speechmaking for compulsory health insurance legislation was particularly attacked, the article stated.

EMERGENCY MEDICAL SERVICE INSTALLED BY FULTON COUNTY SOCIETY

Among other things, the medical profession has been criticized by many because of an inability to get a doctor in time of need. Although we know that much of this criticism is unjust, the mere fact that it exists calls for action. In an effort to obviate such criticism, each member of the *Fulton County Medical Society* has been asked to designate the days he will be available for emergency calls, and two telephone numbers, a day and a night number, which can be called when a doctor is needed will be widely advertised. A system has been devised whereby the names of three doctors, near the caller, will be given, and the doctors will be rotated to avoid having all the requests referred to those at the top of the list.

DISTRICT MEDICAL SOCIETY MEETINGS

Your attention is called to the 3rd District meeting to be held at the Americus Country Club on June 21. The 6th District will hold its summer meeting at the VA Hospital in Dublin on June 28. The members of these district societies are urged to make plans to attend.

RICHARD J. EALES, Director

ERNST & ERNST
Accountants and Auditors
System Service

ATLANTA
First National Bank Bldg.
Delivery Zone 3

Dr. W. G. Elliott
Chairman of The Council
The Medical Association of Georgia
Cuthbert, Georgia

We have examined the records and files maintained in the office of the Secretary and Treasurer of The Medical Association of Georgia. The scope of our examination included a review of the cash transactions for the year ended March 31, 1951. We also accounted for the income of the Benevolent and Building Funds and the Abner Wellborn Calhoun Lectureship Fund for the year ended March 31, 1951, and the assets held in the funds at that date.

The records of cash transactions for six monthly periods selected by us were tested by comparisons of the totals of cash receipts recorded in the cash book with deposits shown by monthly bank statements and by inspection of paid checks, invoices and other data on file in support of the recorded disbursements.

Cash on deposit was reconciled with the amounts reported to us by the depositories.

Securities comprising the entire assets of the Benevolent and Building Funds were being held in safe-keeping by the Federal Reserve Bank of Atlanta, as confirmed directly to us.

Assets of the Abner Wellborn Calhoun Lectureship Fund, consisting of securities and cash, were accounted for by direct correspondence with The Citizens and Southern National Bank, Atlanta, Georgia, Trustee.

A statement of cash receipts and disbursements for the year ended March 31, 1951, and a statement of assets and liabilities of the several funds as at that date are included herein. The amounts stated for accounts receivable and accounts payable were determined from the records of The Association. At the request of the Secretary-Treasurer, we did not correspond with the recorded debtors or creditors to confirm the book balance.

We examined policies evidencing the insurance protection of The Association at March 31, 1951, a summary of which is shown on another page of this report.

ERNST & ERNST
Certified Public Accountants.

Atlanta, Georgia
April 9, 1951

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
THE MEDICAL ASSOCIATION OF GEORGIA
Year Ended March 31, 1951

GENERAL FUND

Cash balance—March 31, 1950.....				\$39,041.28
General receipts and disbursements:				
Receipts:				
Membership dues collected:				
For year 1950.....	\$ 2,603.25			
For year 1951.....	9,678.50			
			\$12,281.75	
Received from American Medical Association for services, postage, etc.....			402.12	
Interest on savings share account No. 6585 of Standard Federal Savings and Loan Association.....			198.85	\$12,882.72
Disbursements:				
Salaries and extra compensation:				
Secretary and Treasurer.....	\$ 3,000.00			
Clerical	5,455.39	\$ 8,455.39		
Less portion allocated to Association Journal.....	3,995.20	\$ 4,460.19		
Administrative and other expenses—as shown by schedule		8,390.70		
Equipment purchased		624.00	13,474.80	
Other receipts and disbursements:				\$ 592.17*
Association Journal:				
Advertising receipts.....	\$16,131.21			
Subscriptions received.....	12,464.75	\$28,595.96		
Less expenses:				
Salaries—allocated	\$ 3,995.20			
Publication expenses—as shown by schedule.....	16,224.58	20,219.78	\$ 8,376.18	
Annual meeting:				

Fees collected from exhibitors.....	\$ 7,818.00			
Less expenses of meeting.....	3,075.71	4,742.29		
Benevolent and Building Funds:				
Interest received—U. S. Savings bonds.....		1,250.00		
Public relations department:		\$14,368.47		
Expenses—as shown by schedule.....	\$10,388.93			
Equipment purchased	72.53	\$10,461.46		
American Medical Association:				
Amounts remitted—Note A.....	\$35,787.50			
Less dues, etc. collected for remittance.....	33,937.50	1,850.00		
Withholding (pay roll) taxes:				
Payments to Collector of Internal Revenue.....	\$ 1,554.24			
Less collected from employees.....	1,225.74	323.50	12,639.96	1,728.51
NET INCREASE IN CASH DURING THE YEAR				1,136.34
				<u>\$40,177.62</u>
CASH BALANCE—MARCH 31, 1951.....				\$ 715.31
ABNER WELLBORN CALHOUN LECTURESHIP				
Cash balance—March 31, 1950.....				
Receipts—dividends on stocks owned by fund.....			\$ 217.52	
Disbursements:				
Purchase of 5 shares Atlanta Gas Light 4½% preferred stock		\$ 527.50		
Fee paid Trustee		10.03	537.53	320.01*
CASH BALANCE—MARCH 31, 1951.....				<u>\$ 395.30</u>

Note A—According to the records of The Association, checks payable directly to the American Medical Association aggregating \$4,188.00 were received and forwarded to that organization during the year ended March 31, 1951, and are not included in the amount shown above.

* Indicates disbursements in excess of receipts.

DETAILS OF EXPENSES THE MEDICAL ASSOCIATION OF GEORGIA Year Ended March 31, 1951

ADMINISTRATIVE AND OTHER EXPENSES

Traveling expenses	\$ 1,787.36
Medical defense—legal	\$ 1,000.00
Postage	660.15
Honorarium to president	600.00
Pension	600.00
Prepayment medical care plans.....	510.70
Contribution to Fulton County Medical Society library.....	500.00
Public policy and legislation.....	445.41
Professional (Audit).....	390.00
Fifty-year buttons	300.00
Stationery and printing.....	292.90
Office supplies and expense	229.10
Telephone and telegraph.....	174.30
Lecture at annual meeting—Dr. Thomas M. Rivers.....	150.00
Subscriptions	72.00
Insurance	71.45
Janitor service.....	71.00
Sundry	536.33
TOTAL	<u>\$ 8,390.70</u>

PUBLICATION EXPENSES

Printing	\$14,627.12
Cuts of illustrations.....	542.12
Envelopes	385.39
Commissions paid	224.68
Postage	200.00
Editorial assistance	100.00
Clipping service	60.00
Copyright fees	48.00
Addressograph supplies and service.....	37.27
TOTAL	<u>\$16,224.58</u>

PUBLIC RELATIONS DEPARTMENT EXPENSES

Salaries:	
Executive secretary	\$ 3,883.33
Clerical	2,425.00 \$ 6,308.33
Traveling expenses	1,184.19
Press, advice, space, etc.	515.24
Printing, literature, and bulletins	505.92
Conferences	365.71
Postage	338.95
Telephone and telegraph	319.04
Stationery and office supplies	308.36
Contribution to Fulton County Medical Society library	300.00
Sundry	243.19
TOTAL	\$10,388.93

STATEMENT OF FUNDS — ASSETS AND LIABILITIES
THE MEDICAL ASSOCIATION OF GEORGIA
March 31, 1951

	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
ASSETS				
Cash	\$40,177.62	-0-	\$ 395.30	\$ 40,572.92
Securities owned	-0-	63,320.00	5,131.50	68,451.50
Accounts receivable	3,733.97	-0-	-0-	3,733.97
Office furniture and equipment	3,328.30	-0-	-0-	3,328.30
TOTAL ASSETS	\$47,239.89	\$63,320.00	\$5,526.80	\$116,086.69
LIABILITIES				
Accounts payable:				
Public relations department	\$ 1,919.86	-0-	-0-	\$ 1,919.86
General	1,936.26	-0-	-0-	1,936.26
TOTAL LIABILITIES	\$ 3,856.12	\$ -0-	\$ -0-	\$ 3,856.12
EXCESS OF ASSETS OVER LIABILITIES	\$43,383.77	\$63,320.00	\$5,526.80	\$112,320.57

Note A—Office furniture and equipment, shown above, does not include items purchased prior to April 1, 1949.

Note B—During the year ended March 31, 1951, \$750.00 was paid from the General Fund which was properly payable from specified funds as follows:

Abner W. Calhoun Lectureship Fund (Dr. Thomas M. Rivers—for lecture at annual meeting)	\$150.00
Benevolent Fund (pension)	\$600.00
TOTAL -	\$750.00

CASH ON DEPOSIT — GENERAL FUND
THE MEDICAL ASSOCIATION OF GEORGIA
March 31, 1951

The Citizens and Southern National Bank, Atlanta, Georgia	\$33,398.84
Standard Federal Savings and Loan Association, Atlanta, Georgia	6,778.78
TOTAL -	\$40,177.62

BENEVOLENT AND BUILDING FUNDS—SECURITIES OWNED
THE MEDICAL ASSOCIATION OF GEORGIA
March 31, 1951

UNITED STATES SAVINGS BONDS

SERIES F

	Cost	Face Amount	Redemption Value
Due June 1, 1956	\$ 7,400.00	\$10,000.00	\$ 8,350.00
Due June 1, 1961	5,920.00	8,000.00	5,960.00

SERIES G

Due July 1, 1957.....	15,000.00	15,000.00	14,280.00
Due March 1, 1959.....	15,000.00	15,000.00	14,205.00
Due January 1, 1960.....	15,000.00	15,000.00	14,265.00
Due January 1, 1962.....	5,000.00	5,000.00	4,890.00
TOTALS	\$63,320.00	\$68,000.00	\$61,950.00

Note—The Association appropriated funds for benevolence and buidling as follows:

Benevolence	\$25,000.00
Building	35,000.00
TOTAL	\$60,000.00

ABNER WELLBORN CALHOUN LECTURESHIP FUND
(THE CITIZENS AND SOUTHERN NATIONAL BANK, ATLANTA, GEORGIA — TRUSTEE)
THE MEDICAL ASSOCIATION OF GEORGIA
Year Ended March 31, 1951

CASH HELD BY TRUSTEE

	<i>Principal Cash</i>	<i>Income Cash</i>	<i>Combined</i>
Balance — March 31, 1950.....	\$ 569.06	\$ 146.25	\$ 715.31
Receipts:			
Dividends received:			
Georgia Power \$6.00 preferred stock.....	-0-	150.00	150.00
Atlanta Gas Light 4½% preferred stock.....	-0-	67.52	67.52
Transferred to "Principal" from "Income"— <i>Note C</i>	190.60	190.60*	-0-
	\$ 759.66	\$ 173.17	\$ 932.83
Disbursements— <i>Note A</i> :			
Purchase of 5 shares Atlanta Gas Light 4½% preferred stock.....	\$ 527.50	-0-	527.50
Fees paid to Trustee.....	-0-	10.03	10.03
	\$ 527.50	\$ 10.03	\$ 537.53
BALANCE — MARCH 31, 1951.....	\$ 232.16	\$ 163.14	\$ 395.30

SECURITIES HELD BY TRUSTEE

	<i>Number of Shares</i>	<i>Market Value</i>	<i>Carrying Amount</i>
Atlanta Gas Light 4½% preferred stock.....	15	\$1,567.50	\$1,567.50
Georgia Power \$6.00 preferred stock.....	25	2,825.00	2,849.50
Southwestern Railroad common stock.....	13	Note B	715.00
TOTAL			\$5,131.50
TOTAL CASH AND SECURITIES.....			\$5,526.80

Note A—During the year ended March 31, 1951, a disbursement was made from the General Fund in the amount of \$150.00 to Dr. Thomas M. Rivers for lecture at annual meeting which was properly payable from the LectureSHIP Fund.

Note B—No published quotation.

Note C—Under the provisions of the trust indenture, "all unexpended income in the hands of trustee on July 1st of each year shall be added to the principal of the trust fund".

* Indicates red figures.

ACCOUNTS RECEIVABLE
THE MEDICAL ASSOCIATION OF GEORGIA
March 31, 1951

EXHIBITORS AT 1951 ANNUAL MEETING

Aloe Company, Inc., A. S.	\$ 275.00	
Baby Development Clinic	175.00	
Brayten Pharmaceutical Company	300.00	
General Electric X-Ray Corporation	300.00	
Marks Surgical Supplies	300.00	
Merrell Company, The Wm. S.	275.00	
Robertson Statement Handling System for the Professions, The	150.00	1,775.00

FOR ADVERTISING IN ASSOCIATION JOURNAL

Atlanta Hospitals	\$ 60.00	
Ballard Optical Company, Walter	9.00	
Brownlee and Lively Certified Dairy	7.00	
City View Sanitarium	12.00	
Coca-Cola Company, The	20.00	
Eager and Simpson	9.00	
Estes Surgical Supply Company	6.00	
Keeley Institute, The	24.99	
Landham and Klugh, Doctors	9.00	
Lane-Rexall Drug Stores	16.80	
Marshall and Bell	7.50	
Mathis Certified Dairy, R. L.	5.50	
New York Polyclinic Medical School and Hospital, The	16.00	
Orr Doctors Building, W. W.	7.50	
Peachtree Sanitarium	25.00	
Pineworth, Inc.	10.00	
State Journal Advertising Bureau of the American Medical Association	1,303.31	
U. S. Brewers Foundation	14.99	
Westbrook Sanatorium	30.00	1,593.59

FOR POSTAGE, SERVICES, ETC.

American Medical Association	215.38	
TOTAL	\$3,583.97	

EQUIPMENT PURCHASED
THE MEDICAL ASSOCIATION OF GEORGIA
Year Ended March 31, 1951

PUBLIC RELATIONS DEPARTMENT

Through cash disbursements:			
Hat stand	\$ 4.95		
Electric fans	67.58	72.53	
Included in accounts payable:			
Multigraph equipment	\$1,221.84		
Office Furniture	135.20		
Electric typewriter	386.90	1,743.94	\$1,816.47

GENERAL

Through cash disbursements:			
Projector	\$ 200.00		
Microphone, etc.	424.00	624.00	
TOTAL			\$2,440.47

ACCOUNTS PAYABLE
THE MEDICAL ASSOCIATION OF GEORGIA
March 31, 1951

PUBLIC RELATIONS DEPARTMENT

Addressograph-Multigraph Corporation	\$ 1,221.84	
Allen-Marshall Company, Ivan	147.20	
Eales, Richard J.	87.60	
International Business Machines Corporation	386.90	
Lane Office Supply Company	11.37	
Matthews, Dan	1.80	
Southern Bell Telephone and Telegraph Company	57.65	
Thompson, Eddie	5.50	\$ 1,919.86

GENERAL

American Medical Association	\$ 250.00	
Artcraft Engraving Company	14.14	
Atlanta Blue Print Company	21.00	
Atlanta Linen Company	3.90	
Atlanta Envelope Company	26.10	
Carithers-Wallace-Courtney, Inc.	23.40	
Franklin Printing and Manufacturing Company	1,448.03	
National Library Binder Company of Georgia, The	35.75	
St. Louis Button Company	100.45	
Southern Bell Telephone and Telegraph Company	9.49	
Western Union Telegraph Company	4.00	1,936.26
TOTAL		\$3,856.26

INSURANCE PROTECTION
THE MEDICAL ASSOCIATION OF GEORGIA
March 31, 1951

LOSS OR DAMAGE TO PROJECTORS, LOUDSPEAKERS, SCREENS, PUBLIC ADDRESS SYSTEM, ETC.....	\$ 3,400.00
FIRE	
Office furniture, fixtures, books, and medical publications in office.....	2,000.00
FIDELITY BONDS	
Secretary and Treasurer	\$ 1,000.00
Miss Viola Berry	1,000.00 2,000.00

COUNTIES REPORTING FOR 1951

Appling County Medical Society

President—J. B. Brown, Jr., Baxley
Vice-President—H. C. McCrackin, Baxley
Secretary-Treasurer—James A. Bedingfield, Baxley
Delegate—F. D. Kennedy, Baxley

* * *

Ben Hill County Medical Society

President—Roy Johnson, Jr., Fitzgerald
Vice-President—W. D. Willcox, Fitzgerald
Secretary-Treasurer—W. C. Sams, Jr., Ocilla
Delegate—G. W. Willis, Ocilla
Alternate Delegate—D. B. Ware, Fitzgerald

* * *

Clarke-Madison-Oconee Medical Society

President—C. H. Bryant, Comer
Vice-President—J. A. Green, Athens
Secretary-Treasurer—William C. Kitchens, Athens
Delegate—M. A. Hubert, Athens
Alternate Delegate—D. F. Mullins, Jr., Athens
Censors—Sam M. Talmadge, W. H. Cabaniss and D. F. Mullins, Jr., all of Athens
PR Chairman—John F. Stegeman, Athens

* * *

Elbert County Medical Society

President—A. S. Johnson, Elberton
Vice-President—Carey A. Mickel, Jr., Elberton
Secretary-Treasurer—John B. O'Neal, III, Elberton
Delegate—D. N. Thompson, Elberton
Alternate Delegate—John B. O'Neal, III, Elberton
Censors—G. A. Ward, F. S. Smith and A. S. Johnson, Jr., all of Elberton

* * *

Forsyth County Medical Society

President—Marcus Mashburn, Jr., Cumming
Secretary-Treasurer—Jim Mashburn, Cumming

* * *

Grady County Medical Society

President—A. B. Reynolds, Cairo
Secretary-Treasurer—J. V. Rogers, Cairo

* * *

Gwinnett County Medical Society

President—J. R. Chastain, Buford
Vice-President—W. J. Hutchins, Buford
Secretary-Treasurer—M. H. Mason, Duluth
Delegate—W. W. Puett, Norcross

* * *

Macon County Medical Society

Secretary-Treasurer—Thomas M. Adams, Montezuma

* * *

MuDuffie County Medical Society

Member—B. F. Riley, Jr., Thomson

* * *

Muscogee County Medical Society

President—Dave Berman, Columbus
Vice-President—O. D. Gilliam, Columbus
Secretary-Treasurer—William G. Love, Jr., Columbus
Delegates—Roy L. Gibson and George M. Hutto, both of Columbus

Alternate Delegates—E. K. Munn and Frank B. Schley, both of Columbus
Censors—George Schussler, Henry H. Boyter and Guy Dillard, all of Columbus
PR Chairman—H. Quigg Fletcher, Columbus

* * *

Newton County Medical Society

President—W. J. Huson, Covington
Secretary-Treasurer—Clarence B. Palmer, Covington
Delegate—W. J. Huson, Covington
Alternate Delegate—J. R. Sams, Covington

* * *

Rabun County Medical Society

Members—J. C. Dover, Clayton, and Lester Neville, Dillard

* * *

Spalding County Medical Society

President—John Venable, Griffin
Vice-President—Jack L. Austin, Griffin
Secretary-Treasurer—John E. Clouse, Jr., Griffin
Delegate—George Brown, Griffin
Alternate Delegate—John E. Clouse, Jr., Griffin

* * *

Suiter County Medical Society

President—Wm. B. McMath, Americus
Vice-President—Henry R. Fenn, Americus
Secretary-Treasurer—Bon M. Durham, Americus
Delegate—J. C. Logan, Plains
Alternate Delegate—Henry B. Fenn, Americus
Censors—Wm. B. McMath, Henry R. Fenn and Bon M. Durham, all of Americus

* * *

Turner County Medical Society

Member—J. H. Baxter, Ashburn

* * *

Wilcox County Medical Society

President—V. L. Harris, Rochelle
Vice-President—Wm. P. Durham, Abbeville
Secretary-Treasurer—J. D. Owens, Rochelle
Delegate—V. L. Harris, Rochelle
Alternate Delegate—J. M. Estes, Abbeville

HEALTHGRAMS

The wise doctor has always considered his patient as a man or woman who is suffering from, say, a growth or a tuberculous infection, rather than the uninteresting container in which some morbid process happens to be placed. Norman B. Capon, M.D., F.R.C.P., Brit. M. J., April 15, 1950.

* * *

Little attention is paid to health, and it is often considered in the negative sense of absence of disease. It is challenging to current thought to point out that health and disease are not static entities but are phases of life . . . Health, in a positive sense, consists in the capacity of the organism to maintain a balance in which it may be reasonably free of undue pain, discomfort, disability, or limitation of action including social capacity. John Romano, M.D., J.A.M.A., June 3, 1950.

THE WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

TWENTY-SIXTH ANNUAL CONVENTION OF THE WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA 1951

While the birds, bees and flowers busied themselves with their spring projects, the Woman's Auxiliary to The Medical Association of Georgia nestled down at the Partridge Inn in August to hold its twenty-sixth annual convention in the month of April. Amid this beauty and peace it was hard to realize that on the other side of this historic city, another history-making event was being made in the construction of a large Hydrogen bomb plant.

On Wednesday, the 18th, the president, Mrs. Lehman W. Williams of Savannah, called the meeting to order at 10:00 a.m.

The pastor of the Lutheran Church of The Resurrection, Rev. Henry E. Horn, gave the invocation.

In quick succession were given our loyalty pledge, the address of welcome and its response.

Then, Dr. Murdock Equen, chairman of the Advisory Committee to the Woman's Auxiliary, gave his report.

Mrs. W. G. Elliott, a past president of the Auxiliary and the Councilor from Georgia to the Woman's Auxiliary to the Southern Medical Association, introduced the past state presidents: Mrs. James N. Brawner, Mrs. William Dancy, Mrs. Bruce Schaefer, and Mrs. J. Harry Rogers.

Mrs. Allen H. Bunce reported on the meeting of the Woman's Auxiliary to the American Medical Association.

Mrs. John W. Turner gave a report on the meeting of the Woman's Auxiliary to the Southern Medical Association.

Then Mrs. Bruce Schaefer, the parliamentarian and a past state president, read the rules governing the convention.

Of the nine district managers only four gave their reports at the convention. Of special interest in the report of the Fifth District was the fact that DeKalb County, with twenty-eight doctors, had a 100 per cent Auxiliary, consisting of their twenty-eight wives.

From the thirty-five county auxiliaries, eleven county presidents or their delegates made their reports.

After some further business, Mrs. Williams recessed the meeting for luncheon, held in the Crystal Room of the Bon Air Hotel. Here, amidst beautiful flowers, was a bountiful buffet luncheon. Favors were at each place. The Augusta Auxiliary participated in a fashion revue with which even a professional model would be content. Later in the afternoon we attended a delightful tea at the home of Mrs. W. W. Battey.

The next day at the Partridge Inn, the general meeting continued.

Dr. A. M. Phillips, president of The Medical Association of Georgia, gave an address entitled "Looking Ahead."

Dr. W. F. Reavis, president-elect of the Medical Association of Georgia, spoke to us about "Expressions on Organization."

Mrs. Mason G. Lawson, third vice-president of the Woman's Auxiliary to the American Medical Association, followed Dr. Reavis. She reminded us that each one of us has a definite part to play in our 60,000 national membership.

The president of the Woman's Auxiliary to the Southern Medical Association, Mrs. L. S. Thompson, emphasized the fact that our state councilor to the Southern Auxiliary should be used truly as the tie that binds.

Four members for whom memorial services were solemnized by music, brief eulogies and a prayer, were Mrs. W. W. Battey, Sr., Mrs. Peter B. Wright, both of Augusta; Mrs. T. E. Rogers, Sr., of Macon, and Mrs. R. E. Jones, of Tifton.

Total registration for the meeting was 195.

The achievement award went to Fulton County, for the donation of 125 pints of blood to the Red Cross by its doctors and their wives.

Richmond County received the scrapbook award and Ware County the Brawner Cup.

Mrs. W. A. Selman, chairman of the Courtesy Committee, expressed beautifully our appreciation of the Richmond County Auxiliary's hospitality.

Among other members participating in the activities at the convention, were Mrs. J. Harry Rogers, public relations; Mrs. John W. Turner, second vice-president; Mrs. Ben Hill Clifton, editorial staff; Mrs. Shelley C. Davis, student loan fund; Mrs. James N. Brawner, honorary president for life; Mrs. T. J. Ferrell, Research in the Romance of Medicine; Mrs. Harold Smith, legislation, and Mrs. Ralph Chaney, budget.

The Auditor's report, showing all accounts in order, was read by Mrs. H. G. Bannister, IIa.

Among those missed at the convention was Mrs. Eustace Allen, the other Honorary President for Life of our organization. A telegram expressing our regret at her absence was sent to her.

Mrs. Lehman Williams read her year's report. Her theme was "Plan, Cooperate, Progress." All of that she did, and in addition, the warmth of her administration will linger on in our hearts.

Mrs. Williams received the presidential pin. Mrs. J. Harry Rogers, in presenting the pin, told her that this was a pin money couldn't buy and furthermore, it could only be acquired through hard work.

The following officers were installed by Mrs. Mason G. Lawson:

Mrs. J. R. S. Mays, Macon, president; Mrs. Ralph Fowler, Marietta, president-elect; Mrs. T. A. Peterson, Savannah, first vice-president; Mrs. R. C. McGahee, Augusta, second vice-president; Mrs. Leo Smith, Waycross, third vice-president; Mrs. Virgil Williams, Griffin, recording secretary; Mrs. M. T. Edgerton, Atlanta, treasurer, and Mrs. Ralph McCord, Rome, historian. In addition to these officers, Mrs. J. R. S. Mays, the president, appointed Mrs. Rhea Richardson, Macon, corresponding secretary, and Mrs. Ralph Chaney, Augusta, parliamentarian.

When Mrs. Mays held the gavel in her capable hands, the Auxiliary turned to her with confidence and thus the twenty-sixth annual convention of the Woman's Auxiliary to The Medical Association of Georgia came to an end with her pledge to render her best to the Auxiliary and an appeal for the cooperation of every member.

MRS. ALLEN H. BUNCE.

NEWS ITEMS

Dr. John T. Akin, Jr., Atlanta, announces the removal of his offices to Suite 202 Medical Arts Building, 384 Peachtree Street, N. E., Atlanta. Practice limited to general surgery.

* * *

The American Gout Association will hold its annual meeting at the Deshler-Wallick Hotel, Columbus, Ohio, May 24, 25, and 26, 1951. Dr. T. C. Davison, Atlanta, president of the Association will preside. Friday afternoon, May 25, Presidential Address—Chronic Hyperthyroidism. Dr. T. C. Davison, Atlanta.

* * *

The American Surgeon, national surgical journal owned by the Southeastern Surgical Congress and Southwestern Surgical Congress, and published in Atlanta, appointed five Atlanta surgeons on the staff. They include Dr. B. T. Beasley, managing editor; Dr. J. D. Martin, Jr., assistant editor; Dr. Frank K. Boland, member editorial board; Dr. A. H. Letton, book review editor, and Dr. R. H. Stephenson, abstract editor.

The American Surgeon formerly was published as *The Southern Surgeon*. Its name was changed and the editorial staff was reorganized at a recent meeting of the Southeastern Surgical Congress in Hollywood, Fla.

* * *

Dr. Enoch Callaway, LaGrange physician and surgeon, was recently honored by the American Cancer Society at a meeting of the Georgia division at the Henry Grady Hotel, Atlanta. He is one of 11 persons to receive national awards for outstanding service in the fight against cancer. Dr. Callaway, director of the West Georgia Cancer Clinic and a past president of the Medical Association of Georgia, managed to enlist 11,000 volunteers in the task of collecting valuable information on cancer. "Education can help save cancer patients," Dr. Callaway emphasized, displaying charts which showed that 47 per cent more of the cancer patients have the ailment in a curable form than 10 years ago. Dr. Callaway, president of the Georgia Division of the American Cancer Society, was awarded a citation and medal from the national society, which was presented by Mr. Rutherford Ellis, Atlanta.

Dr. Sandy B. Carter, Atlanta physician, was elected a fellow of the American College of Physicians at the annual meeting recently held in St. Louis.

* * *

Dr. George W. Fuller, Atlanta surgeon, was elected vice-president of the Southeastern Surgical Congress recently held in Hollywood, Fla. Dr. B. T. Beasley, Atlanta, secretary-treasurer.

* * *

Dr. R. C. Coleman, Sr., Atlanta, was honored for 20 years service as joint secretary of the Georgia State Board of Medical Examiners at a testimonial dinner held at the Atlanta Athletic Club, March 25. More than 100 members of examining boards and their wives attended the dinner at which Dr. Coleman was presented a certificate and a silver service. The certificate was signed by 18 chairmen of examining boards which Dr. Coleman served as secretary since they were consolidated 20 years ago. Dr. Grady Coker, of Canton, member of the Board of Medical Examiners, was toastmaster. The certificate presented to Dr. Coleman expressed "deep appreciation for his faithful, loyal and competent service . . . which has been an inspiration to each member."

* * *

Dr. Daniel C. Elkin, Atlanta, was recently elected president of the American Surgical Association at its meeting held in Washington.

* * *

The Fulton County Medical Society and the English-Speaking Union held a joint meeting at the Academy of Medicine, Atlanta, March 13. Dr. Robert Hughes Perry, of Bristol, England, honorary physician to King George VI of England, was guest speaker. His subject was "Civil Defense Against Air Raids in Atlanta." Dr. Perry is medical health officer for the city and port of Bristol. His recent appointment as honorary physician to the King is one of many honors he has received. He is a fellow of the Royal College of Physicians, and also an honorary fellow of the American Public Health Association.

* * *

The Fulton County Medical Society held its dinner meeting at the Academy of Medicine, Atlanta, May 3. Scientific program: Symposium on Shoulder Pain. Dr. William L. Paullin, Jr., moderator. "Shoulder—Hand Syndrome," Dr. Gordon Barrow; "Injuries to Shoulder Cuff," Dr. Paul Rieth, and "Bursitis and Periarthritis," Dr. Philip Warner, Jr. Dr. Tully T. Blalock, secretary-treasurer.

* * *

Georgia physicians registered at the 14th annual meeting of The New Orleans Graduate Medical Assembly, New Orleans, March 5-8, were Drs. M. C. Adair, Washington; George H. Alexander, Forsyth; W. C. Baxley, Blakely; P. O. Chaudron, Cedartown; R. A. Collins, Jr., Montezuma; R. E. Dallas, Thomaston; J. Kenneth Fancher, Atlanta; F. N. Gibson, Thomson; A. E. Hauck, Atlanta; Frank P. Holder, Eastman; W. R. King, Jr., Griffin; James H. Litton, Tucker; Joseph C. Massee, Atlanta; Lewis W. Moore, Winder; H. E. Rollings, Savannah; F. H. Sams, Reynolds, and Calvin Sandison, Atlanta.

* * *

Dr. William G. Hamm, Atlanta, president of the medical and surgical staff of Georgia Baptist Hospital, delivered a message from the staff at the exercises of 86 graduating nurses of Georgia Baptist Hospital recently held at the Second-Ponce de Leon Baptist Church, Atlanta. Miss Dana Hudson, director of nursing, presented the pins, and Edwin B. Peel, hospital administrator, presented diplomas to the graduates.

The Georgia Medical Society held its regular monthly meeting at 612 Drayton St., Savannah, April 10. Program: "The Red Eye." Grant W. Goldenstar, M. D. Lawrence Lee, Jr., secretary-treasurer.

* * *

Major General David Grant, USAF retired, noted Surgeon-General of the U. S. Air Force during World War II, has been appointed director of the National Blood Program of the American Red Cross effective May 1, it was announced by E. Roland Harriman, ARC president.

He announced that Dr. Grant also will assume the duties of National Medical Director of the Red Cross, succeeding Dr. G. Foard McGinnes, who has resigned effective July 15.

Dr. Ross T. McIntire will continue to serve as chairman of the blood program Medical Policies and Procedures Committee, composed of prominent physicians.

Dr. Russell L. Haden who has been serving as medical director will become associate director and will be responsible for medical phases of the program.

Mr. Harriman lauded Dr. McGinnes who pioneered in the development of the National Blood Program and who had headed for many years the Red Cross health services.

In his new post Dr. Grant will direct all phases of the Red Cross Blood program and he responsible for the further extension of the program to meet increased military and civil defense needs. The program now is providing blood for military requirements both domestically and abroad, and for civilian needs, as well as stock-piling plasma for national defense.

Dr. Grant received his Doctor of Medicine degree from the University of Virginia in 1915. He also is a graduate of the Army Medical School, School of Aviation Medicine, Air Corps Tactical School and Chemical Warfare School. He holds the honorary degree of Doctor of Science from Hahnemann Medical College.

He was awarded the Distinguished Service Medal, and is an honorary member, military division, Order of the Bath, a Fellow of the American College of Surgeons, member of the Association of Military Surgeons of the United States, American Medical Association, Association of Aviation Medicine, District of Columbia Medical Society, Academia Brasileira de Medicina Militar, and of the Delta Kappa Epsilon, Alpha Omega Alpha and Phi Rho Sigma fraternities.

* * *

The Georgia Medical Society held a special called meeting at the Society's Hall, 612 Drayton Street, Savannah, May 4. "The Role of the Private Physician in Tuberculosis Control," Dr. James E. Perkins, Medical Director of the National Tuberculosis Association. Dr. Lawrence Lee, Jr., secretary-treasurer.

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Dr. Charles E. Sax, Savannah, announces the limitation of his practice to obstetrics and gynecology at 19 West Liberty Street, Savannah.

* * *

The Second District Medical Society held its meeting at the Elks Club, Moultrie, April 5. Dr. Robert M. Joiner, Moultrie, president, presided. Minutes of the previous meeting were read and approved. Dr. Joiner appointed a committee of Drs. C. S. Pittman, Jr., M. B. Wine and John F. McCoy to nominate officers for the coming year; to select the place of meeting in October and to arrange for the program. Scientific program, Dr. J. M. Bazemore, Augusta dermatologist, was introduced by Dr. Joiner. After a few remarks, Dr. Bazemore asked Dr. John Mobley, Thomasville, to present a patient for study and discussion. "Indications for Surgery for Peptic Ulcer," Dr. John W. McLeod, Moultrie; "The Problems of Chronic Recurrent Urticaria and Angioedema," Dr. Mervin B. Wine, Thomasville; "Bronchiogenic Carcinoma in a Twelve Year Old," Dr. Walter G. Thwaite, Quitman. Following the scientific

program the committee reported that the next meeting of the Second District would be held in Thomasville, October 4. Drs. Fred Murphy, Thomasville, David Mann, Albany, and Paul Lucas, Tifton were selected to present papers. The following were nominated and unanimously elected as officers: Dr. C. K. Sharp, Arlington, president; Dr. Paul T. Russell, Albany, vice-president, and Dr. Frank A. Little, Thomasville, secretary-treasurer. Dr. Sharp has been in active practice in the Second District for the past 53 years. The meeting adjourned to the Nurses' Home where the physicians and their wives were entertained, followed by dinner served at the Elks Club. Entertainment was furnished by a troupe from Bainbridge. Respectfully submitted, Frank A. Little, M. D., secretary.

* * *

Dr. C. K. Sharp, leading Arlington physician, former president of the Medical Association of Georgia, the Tri-County Medical Society, and now president of the Second District Medical Society, has been named chief of staff of the new City Hospital, Arlington. The hospital, a long red brick building, modern in every detail, marks the materialization of one of Dr. Sharp's dreams for Arlington's improvement and will lay a milestone in the history of the town's progress. Dr. Sharp came to Arlington November 25, 1899. He recalls driving his huggy down the town's wide, unpaved, rutted Main Street at 1 p.m., headed for the hotel where he hitched his horse and pitched into the first day of his medical career. "Cases of malaria were in every house," Dr. Sharp says. At that time, the latest word from the medical schools, including the University of Louisville School of Medicine, Louisville, Ky., where the young doctor had graduated—was that 'malaria' meant 'bad air' and that bad air from swamps, particularly when it was borne on the east wind, was the cause of the disease. It was a year later, in 1900, that Ronald Ross made public his discovery that the anopheles mosquito was the carrier of malaria. As soon as Dr. Sharp learned of the new slant on malaria he went to work to educate the people on the subject, but it was an up-hill job. He has seen malaria incidence decline to zero. Health clinics have stamped out typhoid fever, diphtheria, whooping cough, smallpox and other preventable diseases; antibiotics have brought maladies like pneumonia under control; and the rapid pace of medical progress has kept the doctor busy studying and learning new methods and medicine during the 52 years he has been a physician in Arlington.

"I came to Arlington at the beginning of a great era of medical progress," Dr. Sharp says. "Only about \$35,000 a year of state funds went for public health at that time—now more than \$1,000,000 in State and Federal funds are spent in Georgia to improve the public health." From a store of anecdotes gathered over a half-century of doctoring, he can tell stories that bring tears to the eye, produce a hearty laugh, or raise the hair on the head. But the veteran doctor's best medicine is laughter and his lively sense of humor has remained intact in spite of all the sickness and suffering he has witnessed. He relaxes on fishing trips and enjoys working in his garden after office hours. Cabinet work is his hobby and the filing cabinets, as well as the desk that holds his office typewriter are products of his home work shop. As chief of staff of the City Hospital, Dr. Sharp will head a staff of able physicians, including Dr. James Martin, Edison, vice-president; Dr. T. H. Lawson, Arlington, secretary-treasurer; Dr. J. C. Hattaway, and Dr. J. S. Beard, Edison. Dr. W. C. Baxley and Dr. J. G. Standifer, of Blakely, have been invited to serve on the staff.

* * *

The Sixth District Medical Society will hold its summer meeting at the Veterans Administration Hospital, Dublin, June 28. A tour of the hospital for visiting physicians and their wives will be held from

2:00 to 3:00 p.m. During the afternoon the medical staff of the hospital will present a scientific program. Members of the Woman's Auxiliary of the society and other visiting ladies will be guests at a tea at the Nurses Home of the hospital during the afternoon. At 6:30 p.m. a banquet will be held at the Dublin Country Club.

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Dr. H. Wilder Smith, Swainsboro physician, who was called into active military service, August 14, 1950, when his National Guard Unit was activated, has been transferred from Camp Stewart to Camp Gordon.

* * *

Dr. W. P. Sloan, Jr., Atlanta, was recently certified by the American Board of Internal Medicine.

* * *

The Upson County Hospital, Thomaston, was dedicated March 22, and was opened the next day to receive patients. Dr. T. F. Sellers, Atlanta, director of the Georgia Department of Public Health, gave the dedicatory address. The new hospital has one hundred beds, and was built with County, State and Federal (Hill-Burton) funds. It is modern in every detail, and cost over \$1,300,000.

Staff appointments are as follows: Dr. H. D. Tyler, chief of medicine; Dr. J. M. Kellum, chief of surgery; Dr. R. J. Mincey, Jr., chief of obstetrics and gynecology; Miss Elizabeth Branch, R.N., superintendent of nurses, and Mr. Chris Neubert, administrator.

* * *

Dr. William C. Warren, Jr., Atlanta physician, has been unanimously elected president of the Atlanta Rotary Club, to succeed Malon C. Courts, Atlanta broker, the club recently announced. Dr. Warren will assume office July 1.

OBITUARY

Dr. Joseph Rex Barfield, aged 69, former Atlanta physician, died at his home in Ocala, Fla., May 1, 1951. Born in Alabama, Dr. Barfield came to Atlanta as a young man. He graduated from Emory University School of Medicine, Atlanta, in 1913, and practiced medicine in Atlanta for more than 35 years. Until he retired and moved to Florida several years ago, he was an active member of the Fulton County Medical Society, the Medical Association of Georgia and a fellow of the American Medical Association. He was a member of Glenn Memorial Methodist Church. Surviving are his wife; two sisters, Mrs. W. A. Hodges, Atlanta, and Mrs. T. J. Jordan, Bay Minette, Ala.; brothers, Dr. Hugh H. Barfield, Ocala, Fla.; Dr. J. O. Barfield, Atlanta; Vernon H. Barfield, Jackson, Miss., and several nieces and nephews. Funeral services and burial were in Ocala, Fla.

* * *

Dr. James Edgar Hunt, aged 71, Mount Vernon physician, died March 30, 1951. A native of Washington County, Dr. Hunt was the son of the late Capt. James Allen Hunt and Ruth Smith Hunt. He graduated from the University of Georgia Medical School, Augusta, in 1904. After his graduation he practiced medicine for a year with his brother-in-law, the late Dr. Frank Peacock, of Vidalia. Prior to entering the government service as a contract surgeon, with two years at Hunting Island, S. C., and eight years at Bynum, Ala., he was a resident and practicing physician at Mount Vernon. He was a member of the Montgomery County Medical Society, the Medical Association of Georgia, and the American Medical Association. He was also a member of the Mount Vernon Baptist Church. Mrs. Hunt died February 18, 1951. Surviving are four daughters, Mrs. John W. Green, Marietta; Mrs. Ed Bell, Bynum, Ala.; Mrs. Tom Wollam, Jacksonville, Fla.; Mrs. L. L. Munnerlyn, Fort Hood, Texas; two sons, Edgar A. Hunt, Dublin; James Hunt, medical student at Augusta; a brother; three sisters, and 14 grandchildren. Funeral services were held at the

Mount Vernon Baptist Church with Dr. R. L. Robinson, Dr. Rufus D. Hodges and the Rev. C. L. Shelby officiating. Burial was in the Mount Vernon Cemetery.

* * *

Dr. Theodore Wright Richards, aged 81, retired Captain of the United States Navy Medical Corps, died at his residence, 1213 East 51st Street, Savannah, March 30, 1951. He was born in Portsmouth, Va., the son of the late Comdr. Benjamin Sayre Richards, U.S.N., and Louisa Wright Richards. Following his graduation from George Washington University of Medicine, Washington, D. C., in 1893, he entered the Navy. Captain Richards, a veteran of the Spanish-American War and World War I, was in charge of five different naval hospitals during his career in the medical corps. He was head of hospitals at New London, Conn., Ward's Island, Annapolis, Bremerton and Washington, D. C. He retired in 1934 after 41 years of service. He had made his home in Savannah for the past 14 years. Captain Richards is survived by his wife, Mrs. Lillian Carpenter Richards, Savannah; two daughters, Mrs. Carl Victor Johnson, Savannah and Mrs. Earl H. Spaulding, San Jose, Calif.; two granddaughters and one great-grandson. Graveside services and burial were in Bonaventure Cemetery, Savannah, with the Rev. F. Bland Tucker, D.D., rector of Christ Episcopal Church officiating.

REORGANIZATION OF GEORGIA BETTER HEALTH COUNCIL

On April 24, 1951, at the Piedmont Hotel, Atlanta, the Georgia Better Health Council launched its program for 1951-52. The Council has recently been reorganized under its new name as a privately sponsored agency, formerly having been the Better Health Conference of Georgia, a subsidiary division of the Georgia Citizens Council. Mrs. Shelley Davis, Atlanta, is chairman of the Council.

Financial support for the Council has been pledged by the Medical Association of Georgia, Georgia Division of the American Cancer Society, the Georgia Chapter of the National Foundation for Infantile Paralysis, the Georgia Heart Association, and many other health agencies.

New headquarters are being set up in space provided by the Georgia Heart Association at 11 Pryor Street, S. W. Appointed as chairman of the committees were:

Finance.....	Dr. G. Lombard Kelly, Augusta
Personnel.....	Dr. T. F. Sellers, Atlanta
Organization.....	Dr. T. T. Blalock, Atlanta
Nominating.....	Dr. R. Hugh Wood, Emory University

RECORD MEETING OF A.M.A. INDICATED BY REGISTRATIONS

The 100th annual meeting of the American Medical Association to be held in Atlantic City June 11-15 promises to surpass other meetings in interest and attendance. The record registration was established in 1947 when the centennial celebration of the A.M.A. attracted approximately 16,000 doctors to a meeting at Atlantic City.

"Already the advance registration is greater than in any previous year," according to Dr. George F. Lull of Chicago, secretary and general manager.

Every phase of medicine will be discussed in more than 400 papers to be presented by leading physicians from all over the country. The scientific exhibit will be the largest ever, totaling 290 displays. Special attention has been given to exhibits of interest to the doctor in general practice.

Lectures, demonstrations, motion pictures and television broadcasts of surgical and medical problems will be given. The House of Delegates, A.M.A.'s policy-making body, will meet during the convention. It will consider many topics of importance to the medical profession and national health.

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SPONTANEOUS PNEUMOTHORAX

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Thomasville

Pneumothorax, literally meaning, "Air in the chest," has through usage come to mean air in the pleural cavity. Spontaneous pneumothorax is the term applied to pneumothorax developing from a variety of disease states, in contradistinction to "traumatic or accidental pneumothorax" and "artificial" or "induced" pneumothorax.

Pulmonary diseases complicated frequently by spontaneous pneumothorax are: 1, Tuberculosis; 2, Lung tumors, malignant or benign; 3, Pneumonia; 4, Empyema; 5, Lung abscess, and 6, Pulmonary infarction. The treatment of spontaneous pneumothorax complicating the above disease states is directed not only at the spontaneous pneumothorax, but at the underlying disease. They must be ruled out by diagnostic study.

PULMONARY DISEASES COMPLICATED BY SPONTANEOUS PNEUMOTHORAX

1. TUBERCULOSIS
2. LUNG TUMORS, MALIGNANT OR BENIGN
3. PNEUMONIA
4. EMPYEMA
5. LUNG ABSCESS
6. PULMONARY INFARCTION

In our present discussion we will take up another group, variously termed pneumothorax simplex, simple spontaneous pneumothorax or spontaneous pneumothorax in the apparently healthy.

Spontaneous pneumothorax in the apparently healthy is seen not infrequently by

physicians in active practice. It occurs more frequently in young adult males. It may occur in the newborn or in the seventh decade. Most reports show approximately 10 per cent of cases occurring in women.

In almost all cases there are two complaints present: chest pain and dyspnea. Cough may or may not be an aggravating symptom. The pain may simulate angina pectoris or myocardial infarction. The diagnosis should be suspected when there is hyperresonance on percussion and absent or distant breath sounds. The diagnosis should be confirmed by x-ray examination.

The diagnosis is frequently missed because the pain may simulate myocardial infarction or angina, and the examiner fails to percuss the chest, or listen to the breath sounds. It is common practice today, when chest pain occurs, to have an electrocardiogram done. This may be more confusing, for ST segment shifts may occur, as well as axis shift. T wave inversion may develop. The changes may suggest myocardial infarction or coronary insufficiency. These EKG changes occur by shift in the position of the heart, by massive shunt of the pulmonary circulation, increasing the pressure on the right ventricle, and by reflex coronary spasm, resulting in the development of true heart pain.

Spontaneous pneumothorax in the apparently healthy may develop from a number of pre-existing conditions: 1, congenital cysts and vesicles; 2, localized subpleural blebs; 3, emphysematous bullae; 4, pleural

tear from adhesions; 5. leaky lungs or porous pleura, and 6, Hamman's syndrome, or mediastinal emphysema.

SPONTANEOUS PNEUMOTHORAX IN APPARENTLY HEALTHY INDIVIDUALS

1. CONGENITAL CYSTS AND VESICLES
2. LOCALIZED SUBPLEURAL BLEBS
3. EMPHYSEMATOUS BULLAE
4. PLEURAL TEAR FROM ADHESIONS
5. LEAKY OR POROUS LUNGS
6. HAMMAN'S SYNDROME OR MEDIASTINAL EMPHYSEMA

In most of these conditions a check-valve mechanism is present. During inspiration there is free passage of air, but on expiration the air is trapped. The cyst, bleb, or bulla, consequently enlarges and thins out until rupture occurs. Hayashi (1915) and Kyaergaard (1932) found such check valve mechanisms by microscopic study. This work has been confirmed by numerous investigators.

Congenital vesicles and cysts may form because of the persistence of embryonal tissue which does not differentiate into alveoli. Also defects in the wall of a bronchus, when a check-valve mechanism is present, results in cyst development that on rupture causes spontaneous pneumothorax. This is the cause usually found in infancy and early childhood.

Sub-pleural blebs are formed by interstitial emphysema, the lung tissue being separated from the pleura, and the bleb consists chiefly of attenuated visceral pleura.

Emphysematous bullae are the result of the enlargement and thinning out of the alveolar wall; this results in alveolar wall destruction, forming a large air space. Then weak spots occur in the bullous sac, and eventually it ruptures. There is usually a history of repeated respiratory infections.

Pleural adhesions from pre-existing disease may result in tear of the visceral pleura

and subjacent lung tissue resulting in collapse of the lung.

Leaky or porous lung has been described by Brock (1948). There are minute alveolar leaks through which air escapes from the lung. There is probably a congenital pleural defect present, with the elastic supporting tissue defective. This may tear with minimal trauma, allowing air to escape.

Hamman (1934) first described *mediastinal emphysema*. In over 50 per cent of cases this is associated with spontaneous pneumothorax. The clicking noise, like cellophane crumpling, may be heard 6 feet away. When this occurs the pain is agonizing, resembling that of a dissecting aneurysm of the aorta or acute myocardial infarction.

The treatment of spontaneous pneumothorax varies with the severity and the complications. In approximately 90 per cent of cases the rupture of the bleb or bulla cures the patient. As the rupture occurs the walls fall in, sealing the fistulous opening. Re-expansion then occurs usually within four weeks. Thus the majority of patients need only symptomatic relief from pain and a few days' bed rest. If cough is distressing, sedation may be necessary.

If complete collapse of the lung occurs and tension pneumothorax develops, it may be lifesaving to insert a needle or sealed catheter, connected with a water trap, in the anterior second intercostal space. This relieves the increased pressure and mediastinal displacement. Repeated aspiration or suction should not be done, at least until pleural healing has occurred, for aspiration would keep the check valve open and prevent healing.

Hydrothorax is a frequent complicating factor. Usually no special treatment is indicated.

Hemothorax complicating spontaneous pneumothorax may be a severe complica-

tion, resulting in shock and death. The hemorrhage may occur from a highly vascular pulmonary bleb or bullae, from torn pleural adhesions, or from the bases of torn alveoli. The treatment of shock, loss of blood and tension pneumothorax is of primary importance. The blood should then be aspirated from the chest.

Bilateral spontaneous pneumothorax has been reported by several investigators.

The most serious complication of spontaneous pneumothorax is the development of persistent or recurrent pneumothorax. Recent reports show this to occur in 10 to 15 per cent in most reported series.

In persistent or recurrent spontaneous pneumothorax, where the lung has remained collapsed from two to three months, one of the following complications is usually present: 1, The check-valve mechanism is of such a nature that tension is built up and rupture recurs before the lung can re-expand, or multiple blebs or bullae rupture frequently enough to prevent re-expansion; 2, There may be intrapleural adhesions which are stretched by the collapse of the lung and which act as guy wires, holding the fistula open, and not allowing the lung to collapse completely and thus seal the fistula; 3, There may be fibrosis about the base of the bleb or bulla, which will not allow healing of the fistula, and 4, There may also be, in long standing collapse where fluid is formed or in the presence of hemothorax, the formation of a pleural membrane that prevents re-expansion.

The treatment of persistent or recurrent pneumothorax is a problem for the chest surgeon. Thoracoscopic examination has in some cases been of value, and in a few instances, the surgeon has been able to sever adhesions and close fistulous openings, permitting re-expansion of the lung. The procedure of choice is that of thoracotomy. Blebs and bullae may be sutured and ex-

cised. If indicated, lobectomy may be done. Pleural adhesions may be cut. If a pleural membrane is present decortication may be done. It must be the aim of the surgeon to preserve as much good lung tissue as possible in order to obtain the maximum pulmonary function.

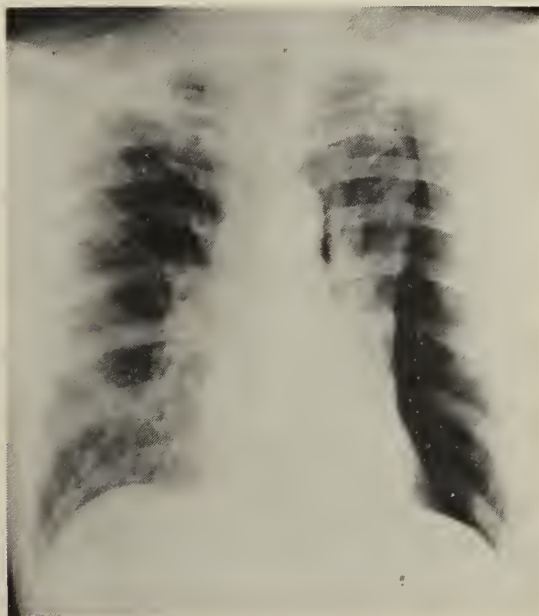


Fig. 1a (Case 1). See case reports.

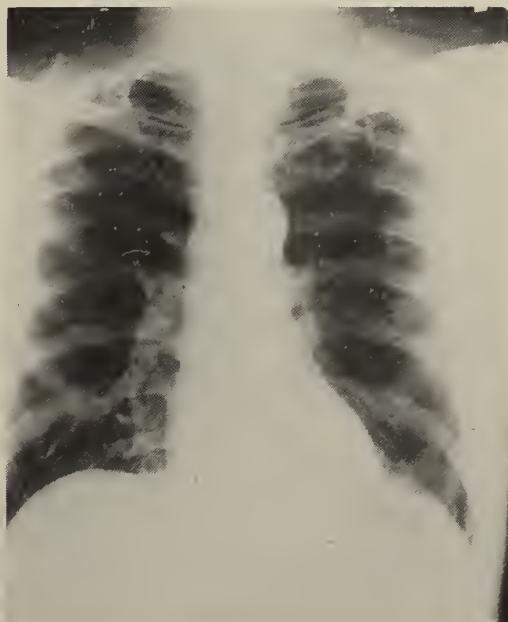


Fig. 1b (Case 1). See case reports.

REPORTS OF CASES

Case 1. Mr. W. I. M., white male, business man, aged 43. On July 6, 1949 was getting out of bed and developed pain in left chest. Pain was continuous and about 11:00 a.m. was examined. P. 130; T. 98 F.;

B. P. 110/80. Blood counts normal. There was hyperresonance over lower left chest. On fluoroscopic examination the left lung was partially collapsed. X-ray on that date was reported normal. EKG showed depression of ST segments in Leads I, II, & III and 1 mm. elevation in lead IVF. Small S waves were present in leads I & II. T wave was inverted in lead I. On July 7, 1949 the chest x-ray showed 30 per cent collapse of left lung. On July 27 the lung was starting to re-expand and four weeks later had returned to normal. He has remained well to date.



Fig. 2 (Case 2). See case reports.

Case 2. G. H. A., white male, aged 22, referred by physicians for supposed heart attack. Had been treated with nitroglycerin, which had given relief from pain. Examined April 7, 1947.



Fig. 3 (Case 3). See case reports.

After going to bed on April 5, 1947, he developed severe left chest pain radiating down left arm.

On examination T. 98 F.; P. 96; B. P. 110/70. Blood counts normal, sed. rate 9 mm/hr. Kahn & tuberculin tests were negative. EKG showed right axis deviation. Fluoroscopic and x-ray revealed partial collapse of left lung. After 1 week rest he returned to college. On April 24 lung had re-expanded. He has remained in good health.

Case 3. J. H. B., carpenter, aged 41, was seen at home March 25, 1946, approximately four hours after acute chest pain that occurred when at rest. Was seen by physician who administered hypo, and who told patient he had a heart attack. On examination left chest was hyperresonant and breath sounds absent. X-ray on following day revealed 40 per cent collapse of left lung. Note the adhesions between the visceral and parietal pleura. Convalescence uneventful. Complete re-expansion on April 27. The patient has remained well.

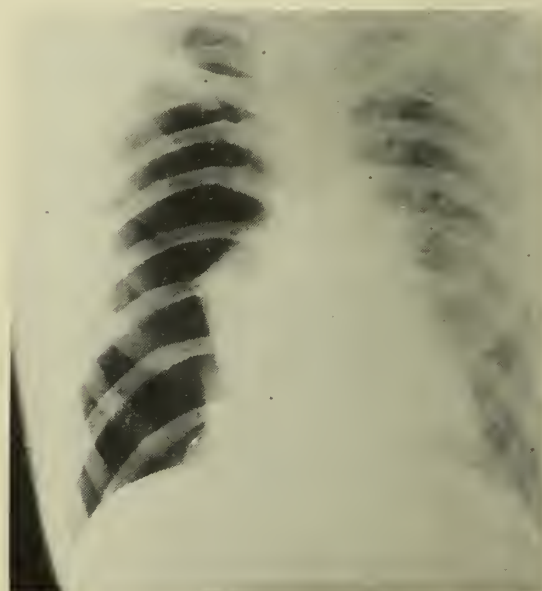


Fig. 4 (Case 4). See case reports.

Case 4. Mr. A. E. D., white male, photographer, aged 24, was seen Sept. 8, 1949. Complained of severe chest and abdominal pain, with radiation to right shoulder. On examination approximately four hours after onset P. 88; T. 99.6 F.; B. P. 120/70. Blood counts and urine normal. Right upper abdomen showed board like rigidity. Right chest hyperresonant and breath sounds absent. X-ray revealed complete collapse of right lung, with displacement of heart and mediastinum to left. Note the prominent bulge in the hilar region. We are inclined to believe that this is ruptured congenital cyst. Patient comfortable in 24 hours, referred to home physician for further care. He has had no recurrence.

Summary

1. Four cases of spontaneous pneumothorax have been presented.
2. Spontaneous pneumothorax is of fairly common occurrence.
3. Diagnosis can usually be made by history, percussion and auscultation.

4. It may be associated with true heart pain. Electrocardiographic changes may occur.

5. Uncomplicated spontaneous pneumothorax requires only rest for a few days.

6. Tension pneumothorax requires sealed water trap drainage.

7. Hemopneumothorax requires aspiration of blood from the pleural cavity.

8. Persistent or recurrent pneumothorax usually requires thoracotomy.

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ABSTRACT OF DISCUSSION

DR. RUFUS F. PAYNE, Rome: Dr. Dillinger has made a most comprehensive review of the literature and of the subject.

There are only one or two things that I would like to point out: First, as a physician in a tuberculosis institution, I would like to point out the fact that spontaneous pneumothorax is a very common occurrence and is much more ominous in significance than is the so-called benign, ideopathic spontaneous pneumothorax due to the complicating factor of empyema, of course.

The second thing is that we have a large number of patients in Georgia now who are taking pneumoperitoneum as a continuation of their collapse therapy, and spontaneous pneumothorax as a complication of pneumoperitoneum is not too uncommon.

It usually occurs on the left side—I do not know why; but everyone dealing with these patients should certainly be on the lookout for it. The usually accepted treatment is to get the air out as soon as possible, because the abdomen will hold much more air than will the chest.

I would like to point out, in connection with the so-called benign spontaneous pneumothorax, the following points:

(Slide) This looks like a typical spontaneous pneumothorax.

(Slide) Here is an over-exposed film. You will note that the patient has a very flat diaphragm.

(Slide) This is a lateral view showing the flattened diaphragm. As I said, the clinician made a correct diagnosis here. He was actually able to induce a pneumothorax in this patient. This patient has a cyst.

(Slide) This shows a little bit of lung tissue on your right and on the patient's right. This occurred after removal of 3,000, 4,000 or 5,000 cc. of air.

(Slide) This patient had a cyst of the right middle lobe, and after a right middle lobectomy you can see that there was a complete re-expansion. This patient is now progressing satisfactorily.

SIGNIFICANCE AND MANAGEMENT OF PERIPHERAL PULMONARY MASSES

OSLER A. ABBOTT, M.D., WILLIAM A. HOPKINS, M.D.,
TED F. LEIGH, M.D., and WILLIAM E. VANFLEIT, M.D.
Emory University

With the increasing use of roentgenograms the clinician is frequently confronted with the management of solitary pulmonary masses. We would like to present our experience with such lesions. A solitary mass may be defined as any peripheral parenchymal lesion greater than one centimeter in diameter and found to be inaccessible to endoscopic visualization and diagnosis; all other types of lesions have been omitted. Some authors have referred to these as "coin lesions"; this is not felt to be a satisfactory term, since many solitary peripheral pulmonary lesions are large and irregular in contour. There are many misconceptions

regarding the significance of these lesions. Prior to the advent of safe thoracic surgery, observation was the recommended treatment. Now early accurate diagnosis and immediate proper therapy are demanded.

Figures 1 and 2 illustrate the type of lesion under discussion.

Table 1. In studying solitary pulmonary masses, the diagnostic methods consist of a detailed history and physical examination, complete roentgenologic studies; adequate laboratory investigation which includes bacteriologic and cytologic study of bronchial secretions, skin tests, bronchoscopy, and in most instances an exploratory thoracotomy. Table 2. This demonstrates

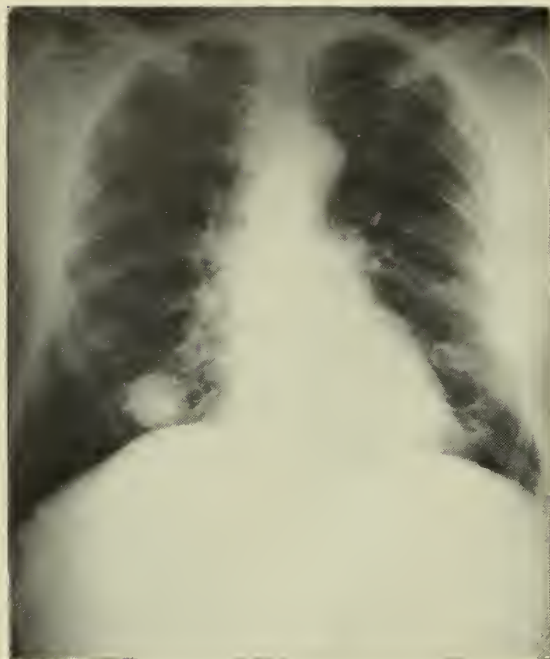


Fig. 1. S. M., white male, aged 73. This peripheral mass in the right lower lung field proved to be a bronchial adenoma.



Fig. 2. Mrs. R. M., white, aged 52. Right lower lobe mass proved to be pulmonary arteriovenous fistula. This patient had no associated cutaneous hemangioma, clubbing, murmur, or polycythemia.

Table 1. Diagnosis Achieved By:

Clinical Findings	4
Sputum (bacteriological)	2
Roentgenographic	12
Bronchoscopy	1
Bronchial secretions (cell study)	2
Aspiration biopsy	3
Biopsy extrathoracic tissue	2
Exploratory laparotomy	1
Exploratory thoracotomy	54

Table 2. Diagnostic Methods

1. History and physical examination
2. Roentgenological procedures
3. Laboratory tests
 - a. Sputum-bacteriological
 - b. Sputum-cell studies
 - c. Skin tests
4. Bronchoscopy
5. Exploratory thoracotomy

in statistical form the relative value of the diagnostic methods utilized. First, the clinical findings were of diagnostic value in but four patients; bacteriologic studies in two, both active tuberculosis. This was interesting considering that 17 of the 81 patients were subsequently proven to have tuberculous lesions. Roentgenologic study was the only diagnostic aid of major value; even here only 12 of the 81 patients were positively diagnosed pre-operatively.

Cytologic study of bronchial secretions, obtained either at the time of endoscopy or from sputum specimens, was distinctly dis-

appointing. Of 39 patients with subsequently proven malignancies, positive cytologic diagnosis was obtained in only two cases. This deserves emphasis in that it again demonstrates the complete lack of significance of a negative cell study. In 54 patients a satisfactory diagnosis could be achieved only by exploratory thoracotomy despite the intensive use of all other investigative measures.

Table 3. Symptoms

	Present	Absent
Neoplasms	28	11
Tuberculosis	4	13
Granuloma	9	0
Lung abscess	6	0
Miscellaneous	7	3
	54	27

Table 4. Symptoms (54 Pts.)

Cough	44
Pain	25
Weakness and fatigue	23
Weight loss	23
Hemoptysis	15
Dyspnea	11
Wheeze	8
Fever	7

In these 81 patients we studied their symptomatology with the hope that it might be of some significance. A review of Table 3 shows that the symptoms appeared with

essentially the same incidence, whether the lesions were neoplastic, tuberculous, granulomatous, or of a miscellaneous type. Table 4 presents the symptoms encountered, and they are the symptoms expected in patients with pulmonary disease. There was no specificity of the symptoms, and this table only emphasize the deficiency of the clinical picture as a means of deriving a satisfactory diagnosis in patients with peripheral masses. The management, therefore, has consisted of a detailed study with particular avoidance of a "watch and wait" regimen. Exploratory thoracotomy was utilized when indicated. To some this may appear to be a radical approach, but it is a necessary one considering the inadequacy of the other diagnostic methods.

Let us now briefly present the statistical data relative to the significance of these lesions. Table 5. Of these 81 peripheral

Table 5. Types of Peripheral Masses

Neoplasms	39
Tuberculosis	17
Granulomas	9
Lung abscess (blocked)	6
Congenital Defects	5
Miscellaneous	5
Total	81

masses, 39 were neoplastic, 17 were tuberculous, nine granulomatous, six were blocked cavities, five were congenital defects, and five were of a miscellaneous type. The significance of neoplastic and tuberculous lesions was obvious. Surgical removal was felt to be indicated in each case. Four tuberculomas measuring less than one centimeter in diameter and diagnosed by laminagraphy were not excised but were kept under close observation. In 72 of these 81 cases the lesion was extirpated. In only one instance could surgery have been avoided. There were no major complications except for one operative mortality. This occurred due to a cardiac complication following

total pneumonectomy for an advanced primary cancer.

Table 6. Types of Neoplasms

Primary Pulmonary Malignancies	31
Primary Pre-malignant Tumors	2
Metastatic Tumors	6
Total	39

Table 7. Types of Primary Neoplasms

Adenocarcinoma	15
Squamous carcinoma	11
Undifferentiated carcinoma	4
Sarcoma	1
Adenoma	1
Hamartoma	1
Total	33

Table 8. Types of Metastatic Neoplasm

Carcinoma of Pancreas	1
Carcinoma of Cervix Uteri	1
Seminoma	1
Fibro-sarcoma of leg	2
Buccal Carcinoma	1
Total	6

Table 6 shows the type of lesion present in the 39 neoplastic masses. Thirty-one were primary pulmonary malignancies. Two were adenomas with definite malignant potential. Six were metastatic tumors. Table 7 shows the types of primary pulmonary neoplasms found. The primary pulmonary carcinomas were essentially the types usually seen, but the incidence of adenocarcinoma was found to be rather high. This was not felt to be of statistical significance. Rare lesions, such as sarcoma and the various so-called "benign" pulmonary tumors, appeared in their expected incidence. Table 8 shows the type of metastatic lesions found. In some instances extra-pulmonary masses were present. In one instance a solitary pulmonary metastasis was excised, inasmuch as no other metastasis had appeared during an adequate period of control following the excision of the primary lesion.

Table 9. In the 25 granulomatous lesions only 17 proved to be tuberculous. This is of significance because of the prevailing misconception that the majority of such lesions should be considered tubercu-

Table 9. *Granulomatous Lesions*

<i>Tuberculosis</i>	17*
<i>Tuberculoma</i>	12
<i>Conglomerate tuberculosis</i>	3
<i>Blocked cavity</i>	2
<i>Granuloma (non-tuberculous)</i>	9
<i>Non-specific</i>	5
<i>Lipoid</i>	2
<i>Mycetoma</i>	2

*4 diagnosed by x-ray only

Table 10. *Congenital Defects*

<i>Pulmonary Arteriovenous fistula</i>	3
<i>Pulmonary Cyst (Blocked)</i>	2
<i>Total</i>	5

Table 11. *Miscellaneous Lesions*

<i>Xanthoma</i>	1
<i>Inspissated Interlobar Empyema</i>	1
<i>Hyperplastic Peribronchial Nodes</i>	1
<i>Encapsulated Fluid</i>	1
<i>Pulmonary Infarct (organized)</i>	1
<i>Total</i>	5

lous until proven otherwise. Table 10 denotes the type of congenital defects found; namely three pulmonary arteriovenous fistulas and two blocked congenital pulmonary cysts.

In the miscellaneous group (Table 11), there was one xanthoma which had an associated area of abscess formation. This could not be controlled medically and required excision. In the second case hyperplastic peribronchial lymph nodes had produced destruction of the pulmonary tissue beyond the area of resection, and resection of this bronchiectatic tissue was necessary in the treatment of the patient. The organized pulmonary infarct had become chronically infected, and the destroyed pulmonary tissue required resection for cure. The encapsulated interlobar fluid was the only instance in the series in which it was felt that the operative procedure might be considered inessential to the clinical course of the patient. In review, therefore, we must consider that in all instances these lesions are significant. It is our feeling that any peripheral pulmonary mass, one centimeter or larger, must be considered to have a definite malignant potential. The fact that 39 of the 81 patients eventually were proved to have neoplastic lesions emphasizes this point.



Fig. 3. C. R., white female, aged 65. See context for radiographic description.

We believe that the value and limitations of different types of roentgenologic studies in these patients is a matter of primary importance in the discussion of these lesions. Although the lesion was not completely diagnosed except in 12 of the 81 patients, roentgenographic studies were of immeasurable help. (Fig. 3). In this case the lesion is in the anterior division of the right upper lobe, has lobulated borders, and contains no visible cavitations or calcifications. Note that there is enlargement of the nodes in the right hilum, and there is a mild degree of atelectasis of the right upper lobe. On exploration this proved to be a bronchiogenic carcinoma.

Less characteristic of malignancy is the lesion shown in another case (Fig. 4). In a fifteen month period, the time elapsed between the films in figures 4 and 5, there was no significant change in the size of the lesion; but at operation this was found to be bronchiogenic carcinoma. From this case it can be stated that lesions that remain sta-



Fig. 4. G. C., white female, aged 62. Small lesion in right upper lobe showed no radiographic change over fifteen month period. At operation this proved to be a grade III adenocarcinoma.



Fig. 6. R. S., white male, aged 64. Pulmonary arteriovenous fistula. Fluoroscopic examination showed pulsations of wide amplitude in mass. Patient had marked clubbing, polycythemia, and a murmur.

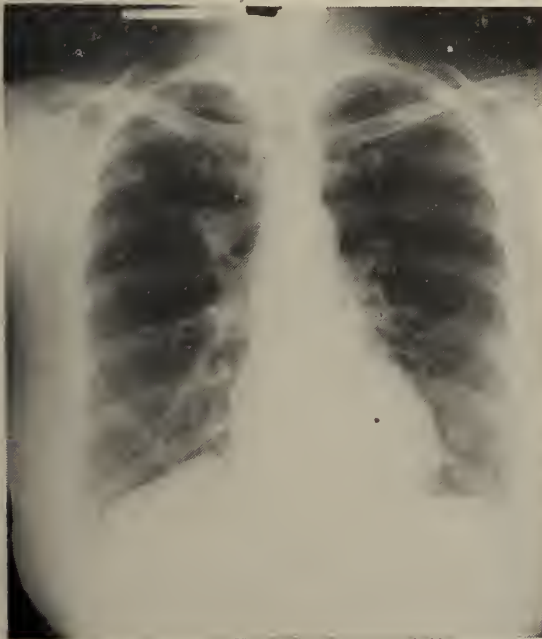


Fig. 5. Same patient as described in figure 4 fifteen months later.



Fig. 7. A. S., white male, aged 47. Granuloma of left lower lobe. This routine film does not prove calcification.

tionary in size over a period of time can be of grave significance.

Further, fluoroscopy shows additional findings not apparent on routine films. The film (Fig. 6) reveals a mass in the right lower lobe with broad bands of in-

creased density radiating from it to the right hilum. Under the fluoroscope intrinsic pulsations were noted in the mass, suggesting



Fig. 8. Laminogram of lesion seen in figure 7. Well defined calcium deposits are now demonstrable.

the correct diagnosis of an arteriovenous fistula of the lung.

We have used laminagraphy frequently and have found it to be of value in certain lesions (Fig. 7). In this case a small nodulation was noted on the routine film as shown. The presence of calcification was equivocal. In the laminagram in figure 8, well-defined calcium deposits are demonstrated. On the basis of this, our diagnosis was granuloma, and it was felt that surgery was not indicated.

Figure 9 is a laminagram of bronchiogenic carcinoma. The principal finding is the presence of finger-like projections extending from the irregular lesion into the surrounding tissue. This was not apparent on the routine film. In our experience, this finding is highly in favor of malignancy.

Angiocardiography (Fig. 10) is a radiographic procedure developed within the



Fig. 9. J. S. C., white male, aged 52. Bronchiogenic carcinoma. Laminagram. Note the finger-like projections extending peripherally from the mass.

past twelve years; its use is indicated in highly selected cases. With angiocardiography, this mass in the right lower lobe opacified, and thus the diagnosis of an arteriovenous fistula was established.

The mass shown in figure 11 is a bronchiogenic carcinoma which has obstructed some vascular branches to the left upper lobe. On angiocardiography the obstructed branches failed to fill, and one can see a distinct difference in the vascularity of the right and left upper lobes.

Lastly, in our experience bronchiography is of no particular benefit and is seldom indicated in patients having peripheral pulmonary masses. Usually a bronchogram will show only obstructed and displaced bronchi. Such observations are more accurately made with bronchoscopy.

Summary and Conclusions

We have briefly reviewed the subject of peripheral pulmonary masses. We again wish to emphasize that the lesions under consideration were peripheral to the main-stem bronchi. Analysis of the 81 patients

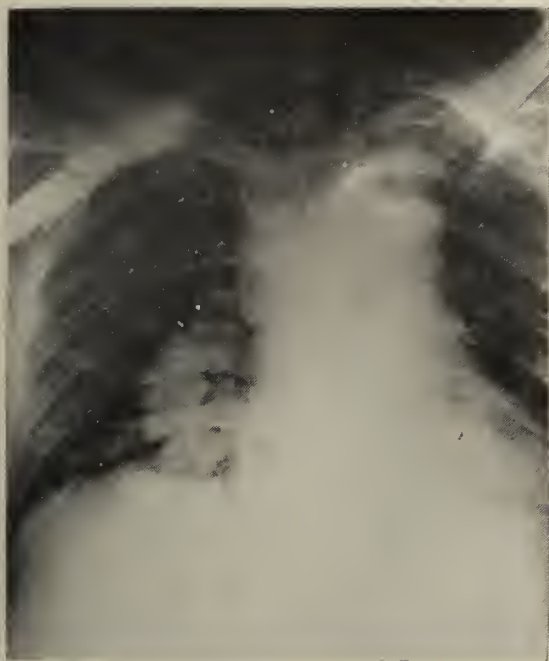


Fig. 10. G. M., white male, aged 44. Angiocardiogram showing opacification of a pulmonary arteriovenous fistula of right lower lobe. This patient presented classical clinical picture.



Fig. 11. W. N., colored male, aged 61. Angiocardiogram demonstrating vascular obstruction in left upper lobe arteries.

presenting solitary peripheral pulmonary masses revealed that in 39 cases the shadow was due to neoplastic causes. This fact alone emphasizes the importance of these solitary lesions. Unfortunately, in many instances these lesions had been observed without definitive diagnosis until enough time had elapsed that curative operative procedures could not be carried out. In several instances these lesions did not demonstrably change size or shape during a period of prolonged observation, and yet the lesions proved at operation to be malignant pulmonary neoplasms; this finding is felt to be of major significance.

The inability accurately to diagnose these lesions by a detailed preoperative study in 54 instances demonstrates the inadequacy of the diagnostic measures that are available at the present time. We feel that the proper management of these lesions should consist of immediate adequate detailed clinical, laboratory, and roentgenologic study as soon as these lesions are discovered. If a truly

definitive diagnosis cannot be achieved by these means, then exploratory thoracotomy is mandatory. The practice of "observation" and prolonged multiple repeated x-ray studies is considered untenable in the proper management of these lesions. An adequate roentgenologic study of these lesions must include PA and lateral x-ray films, fluoroscopy, and barium visualization of the esophagus in all cases.

Laminagraphic studies in both the postero-anterior and lateral planes have proven to be a valuable adjunct in the study of these lesions. Angiocardiographic examinations may be of value in certain selected cases. Bacteriologic study of the sputum is of significance only when such study reveals the presence of *M. tuberculosis*, but we wish to emphasize that in 15 tuberculous lesions, repeated negative sputum studies were obtained. Papanicalaou cell studies of the sputum and the bronchial secretions proved to be a major disappointment, and negative cell studies in no way rule out the possibility of malignancy. Exploratory thoracotomy has proven to be a fundamental diagnostic and therapeutic aid in the proper management of these lesions.

THE CLINICAL RECOGNITION AND TREATMENT OF PULMONARY EMBOLISM AND ITS PRODROMES

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Atlanta

It has long been well known, and frequently emphasized in the literature, that the postoperative or post-traumatic patient who on the fourth to seventh day develops fever, leg pain and swelling, tender calf veins and a positive Homans' sign, has phlebothrombosis, and is in grave danger of pulmonary embolism. It is further well recognized that when such an individual develops severe chest pain, hemoptysis, cyanosis and collapse, embolism has occurred, and that the diagnosis can often be proved by certain characteristic roentgenographic and electrocardiographic changes. Recently, however, it has been shown that thrombo-embolic disease, which includes phlebothrombosis and/or pulmonary embolism, does not always occur in these typical circumstances, or give such unmistakable warning, or present such classic findings, and that the diagnosis must frequently be made on clinical grounds alone. This has been forcibly demonstrated to me by the 14 cases which form the basis of this report. All of these cases have been observed within a period of some 18 months and in the course of a more or less routine practice of internal medicine. Any attempt to discuss comprehensively thrombo-embolic disease or to review the voluminous literature on the subject would be impossible in a short paper, and it is intended here merely to summarize the lessons learned from this small group, emphasizing the need for awareness of the variable manifestations of

the disease and the importance of proper treatment.

Summarized in the first two columns of the accompanying table are the circumstances under which the disease, either phlebothrombosis or pulmonary embolism, or both, occurred. One individual had a pulmonary embolism after immobilization of a fractured leg in a cast for 30 days. Two developed the disease after myocardial infarctions, at intervals of 18 and 21 days respectively. One episode occurred in an elderly female during treatment for a chronic leg ulcer, and one during convalescence from bronchopneumonia. Two postoperative urologic patients developed vascular complications at intervals of three and nine days after prostatic surgery. One young woman with endometriosis came into the hospital for pelvic surgery and had a pulmonary embolism on the morning the operation was to be performed. One man developed typical leg signs twelve days after major abdominal surgery. One fatal embolism occurred on the eighth day of hospitalization for typical thrombophlebitis due to varicose veins, after the phlebitic process was apparently cured. Four cases occurred spontaneously, although one was in a woman who had had phlebothrombosis and pulmonary embolism three years before, and one in a young man whose mother and two brothers had previously had the disease.

Even from this very small group it can be seen that thrombo-embolic disease can occur with *any* type of illness, either medical or surgical, at any time during the ill-

TABLE 1. PULMONARY EMBOLISM AND ITS PRODROMES

Case	Sex	Age	Predisposing Condition	Day of Illness or Hospitalization	Presenting Symptoms or Signs	Other Clinical Features at Onset	Later Developments
1	M	52	Leg fracture with cast	30th	Chest pain, dyspnea	Friction rub. Tenderness in calf. T: 101° P: 115. Diagnostic x-ray	Prompt improvement
2	M	60	Myocardial infarction	18th	Extreme faintness and dizziness, slight chest pain	T: 99.2° two days later	X-ray later showed signs of pulmonary infarction.
3	F	76	Myocardial infarction	21st	Swelling of legs	T: 101°	Pleural effusion after 2 days.
4	F	76	Leg ulcer	11th	Dyspnea	Tachycardia. Basal rales	Diagnostic x-ray on 2nd day. Typical leg signs on 4th day.
5	F	66	Broncho-pneumonia	12th	Calf pain	Positive Homans' sign. T: 99°	Prompt improvement
6	M	57	Carcinoma of prostate with retropubic prostatectomy	9th	Faintness	T: 102° P: 140 BP: 70/50 Auricular fibrillation	Sudden pain in calf 2 days later with positive leg signs
7	M	69	Benign prostatic hypertrophy with transurethral resection.	3rd	Calf pain	T: 99.4° Calf tenderness	Prompt improvement
8	F	32	Endometriosis	1st	Pain in chest	T: 101° P: 110	Pleural friction rub next day. Positive leg signs.
9	M	67	Carcinoma of the pancreas with Whipple operation	12th	Tenderness in calves	T: 99.2° P: 100 Positive Homans' sign	Prompt improvement
10	M	62	Thrombophlebitis with varicosities	8th	Classical thrombophlebitis	Pain, swelling and tenderness in leg and thigh. Temperature elevation.	Sudden death from Pulmonary embolism on 8th day. (Treatment had been stopped.)
11	F	50	Phlebothrombosis 3 years before		Calf pain	Tenderness. Swelling (by measurement). Positive Homans' sign.	Prompt improvement
12	F	50	None		Calf pain	T: 99.2°. Tenderness and in leg. Positive Homans' sign.	Prompt improvement
13	M	36	None		Chest pain	T: 101° Pleural fluid on x-ray.	Typical leg signs ten days later. No treatment.
14	M	34	Virus pneumonia 1 month before. Mother, 2 brothers, and 1 nephew have had thromboembolism.		Calf pain	T: 99 P: 90 Tenderness, swelling and induration in the calf. Positive Homans' sign.	Prompt improvement

ness or convalescence and, most important of all, in apparently perfectly healthy individuals. The latter group is the one which may most frequently be misdiagnosed or missed altogether. It must be emphasized, therefore, that one cannot look for signs of thrombo-embolism only in the postoperative of post-traumatic cases in the so-called crucial period, but that it must be suspected in any individual who presents possible manifestations of it.

Summarized in the last three columns of the accompanying table are some of the multiple and sometimes bizarre ways in which the disease may manifest itself. Only seven of these patients initially presented the typical signs of phlebothrombosis—temperature and pulse elevation, leg swelling and tenderness, palpable veins and a positive Homans' sign, and in nearly all of these some of these signs were absent. Homans' sign was particularly unreliable. In three cases there were positive leg signs only after embolism had unmistakably occurred. In one there were never any leg signs, and the embolism may have come from the leg veins or from a mural thrombus in the heart. In one there were signs of thrombophlebitis, which theoretically does not often give rise to embolism.

The pulmonary embolism presented itself rather typically in a few instances, but in others by varying degrees of chest pain simulating pneumonia, pleurisy or "neuralgia", by disturbances in cardiac rhythm, by congestive heart failure, or simply by faintness or dizziness. Not one of these individuals had hemoptysis. In none of these cases was the electrocardiogram of real diagnostic value, although it was taken in four instances where the embolism was suspected; and it has been noted by many observers that the changes are too fleeting and too non-specific to be more than confirmatory, even when found. None of the

four tracings showed the classic "acute cor pulmonale" pattern. The x-ray signs, while helpful as confirmation of the diagnosis later, are too often equivocal or appear too late to be of early diagnostic value. Generally speaking, the diagnosis of pulmonary embolism, as well as that of phlebothrombosis, must be made on clinical grounds alone, and it is essential to remember that the clinical manifestations are many. These cases illustrate only a few. Reliance must not be placed on the "classical signs", for many of them may be missing, and any unusual leg or chest symptoms or signs must lead to a suspicion of the disease.

No attempt will be made to settle the controversy between the medical and surgical treatment of thrombo-embolic disease. I am merely more familiar with the medical management, and in my hands it has been fairly successful. In this group of 14 cases, all managed with anticoagulants, there was one death, occurring after treatment was stopped too soon, and only one case with disabling after effects, consisting of pain and edema of the leg. In no case did pulmonary embolism occur during adequate therapy. Where laboratory facilities are available for proper control and where the physician has a reasonable familiarity with anticoagulants, most cases can be properly managed with this form of therapy. The important thing is to make the diagnosis early, to give adequate doses of heparin and/or dicumarol and to continue treatment long enough to be reasonably certain that the process has subsided. It has been my practice to use heparin in some form for the first two or three days, or until the dicumarol, administration of which is begun immediately, has produced a prothrombin time of from 10 to 30 per cent of normal. The heparin is then discontinued and dicumarol continued for from 8 to 14 days, depending on the clinical improvement.

Each day's dose of dicumarol is, of course, regulated according to that day's prothrombin time. Ambulation is begun while therapy is still in progress. Adjunctive measures consist of complete bed rest at first, elastic bandaging of the legs, and various measures to relieve chest pain, cough and dyspnea. This program may or may not be superior to vein ligation. The essence of treatment is that it be early and adequate, no matter what form it may take.

In conclusion, it should be emphasized first, that pulmonary embolism and its usual prodrome, phlebothrombosis, are common diseases, occurring as complications of nearly every type of illness, and frequently spontaneously. Secondly, these conditions may manifest themselves in many variable ways, and the key to diagnosis lies in clinical recognition, which in turn comes from a high index of suspicion and familiarity with these manifestations. Thirdly, adequate therapy is essential, and produces very satisfactory results.

From the Lowance Clinic.

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ABSTRACT OF DISCUSSION

DR. C. E. RUSHIN, Atlanta: I agree with Dr. Hill that the medical treatment is much better than the surgical treatment. In some instances we have to resort to surgery, such as ligation of the superficial femoral vein, and occasionally the inferior vena cava.

In patients past 55 years of age I do not think there is any disease that is more fatal than thromboembolic disease. Bauer, of Sweden, reports 259 patients with pulmonary emboli, and only one death. That death was in a patient who had gotten up after the anticoagulant therapy had been discontinued. I want to warn you to be sure to continue the anticoagulant therapy for several days, and have the patient ambulatory with the prothrombin 20 per cent or less.

Allen at the Mayo Clinic follows this procedure, and it can be followed in communities where they do not

have laboratory facilities: Give 50 mg. of undiluted heparin, intravenously, every four hours, and then put the patient in an oxygen tent, and do not give him any opiates at all.

Of course, while you are giving heparin you do not have to run any prothrombin time, as you do when giving dicumarol. In fact, we very seldom run the coagulation time. At the same time we give the heparin we start the patient on 300 mg. of dicumarol and then run the prothrombin time at three hours and a half every morning after the last dose of heparin.

Digitalis cannot be given when using heparin, because it will neutralize the effect of the heparin. Allen gives 1/60 grain of atropine for dyspnea, and then intravenously and repeats in 4 to 6 hours.

I have been using anticoagulant therapy for about ten years; and so far we have had no mortalities. We recently had one of our neurosurgeons in Atlanta, who had a cartilage removed from his knee, who would not move after his operation. He remained almost stiff as a cadaver with that leg, anyway, and although we examined him every day we could not determine that he had any phlebothrombosis. He developed pulmonary embolus, and he was treated as I mentioned a moment ago. He is recovering very nicely.

Probably the chief sign of phlebothrombosis is pressure on the calf of the leg. If you have pain there you can be fairly certain that there is a small clot in one of the muscle veins. The Homans' sign is frequently not very reliable.

When a patient has thrombophlebitis in a varicose vein, if it is in the lower part of the vein it is advisable to do a resection of the great saphenous vein at the saphenofemoral junction; or, if that is not done, bind the leg very firmly and get the patient out of bed.

DR. RAYMOND F. CORPE, Rome: There are several factors about this paper that I would like to emphasize. Thirty-nine of the lesions were neoplastic and 17 were tuberculous, which means that approximately 70 per cent of these peripheral pulmonary lesions were either neoplastic or tuberculous.

Another interesting factor was the point that there was one operative mortality in 72 surgical extirpations of lesions. This is a mortality rate of 1.5 per cent approximately.

Another interesting factor was the point brought out that 54 of the 81 cases discussed were not accurately diagnosed preoperatively. This is a percentage rate of about 68 to 70 per cent.

I am merely bringing this out to point up one fact, that the most accurate method we have at our disposal is exploratory thoracotomy for the peripheral pulmonary lesion.

There was a 1.4 per cent operative mortality. We know that with neoplastic lesions that are left untreated there is a 100 per cent mortality associated with them.

The final picture on tuberculomas, so-called, of the lung, is not known. We read in the literature of many reports dealing with the surgical extirpation of tuberculomas, yet so far we see no reports coming out on a statistically significant group of tuberculomas that have been followed to see how many of these patients do get into trouble.

I want to show a series of slides on one patient, to show that the tuberculoma of the lung is a very dangerous lesion to merely observe.

(Slide) You will see in the first anterior interspace this round lesion. That film was taken in 1947.

(Slide) Here is the same lesion, which is coming down more firmly, with pneumoperitoneum beneath it, also in 1947.

(Slide) Here is the lesion in 1948, as you can see, beneath the clavicle in the first anterior interspace on the left side.

(Slide) Here is the picture in 1950. This lesion had been observed for over three years, and it blew up in the face of this type of observance.

CHLOROMYCETIN TREATMENT OF TYPHOID FEVER

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and

WM. H. BONNER, M.D.

Athens

Introduction: Until about three years ago typhoid fever was an illness of prolonged nature and left the patient very weak and debilitated. However, the incidence of typhoid has been greatly reduced through the use of typhoid-paratyphoid vaccine. In 1948 Woodward et al¹ reported ten cases of typhoid treated and apparently cured with the use of chloromycetin. During the last two years several other authors^{2 3 4 5} have reported successful treatment of typhoid fever with chloromycetin. The majority of the cases of typhoid fever reported has been in children.

The purpose of this paper is to report 7 cases of typhoid fever and one case of paratyphoid fever successfully treated with chloromycetin.

Clinical Findings: Ages. The ages of this series of patients varied from 4 to 51 years; there were 3 females and 4 males. Only one patient was a Negro. No patient had a history of previous immunization for typhoid, and all were from rural areas, drinking water being obtained from wells.

On admission, these patients appeared acutely ill, complained of general malaise, diarrhea, fever, and pain in the abdomen. They appeared weak but no patient was irrational. Duration of diarrhea and fever was 7-10 days. Three of the patients were children in the same family and were referred to St. Mary's Hospital by a physician in one of the adjoining counties with a diagnosis of typhoid fever. The other cases were admitted for diagnosis. Physical examination revealed skin hot and dry, pulse rela-

tively slow, and temperature elevations spiking to 103-104 F. Mucosa of tonsils and throat were moderately injected. Three patients presented signs of meningeal irritation with a stiff neck, positive Kernig and Brudzinski signs. Spinal fluid examination in each was essentially normal. The spleen and liver were not significantly enlarged, but generalized abdominal tenderness was present. No particular lymphadenopathy was present. The heart and lungs showed nothing remarkable.

Laboratory findings consisted of a relative leukopenia with a mild to moderate anemia. Routine stool culture showed the presence of *E. typhosa*. Later, agglutination studies revealed positive agglutination titers up to 1:640 to 1:1280 with both typhoid-H and typhoid-O antigens. One patient's serum showed paratyphoid-B agglutination positive in 1:640. The stool specimens were liquid, thick, had a foul odor and were dark red, resembling currant jelly.

General Pathology: No deaths occurred in this series. In typhoid fever the most prominent pathologic changes occur in the ileum, the mesenteric lymph nodes, liver and spleen. In the ileum small foci of coagulation necrosis occur in the Peyer's patches, slough, and leave oval shaped superficial ulcers. The base of the ulcer is smooth and there is intense mononuclear cell infiltration. Some bleeding from the ulcer occurs and peristalsis is active, resulting in frequent bowel movements and the semi-liquid currant jelly colored stools. The regional lymph nodes enlarge, show severe hyperplasia of the reticuloendothelial elements,

and occasionally show small foci of abscess formation and minute colonies of bacteria. Secondarily, the liver and spleen become slightly enlarged and there is infiltration by mononuclear cells, lymphocytes and foci of necrosis.

Treatment: After the diagnosis of typhoid fever these patients were given general supportive care, antipyretics, fluids, diet as indicated and chloromycetin. Two schedules of therapy were generally followed in these patients. In four patients an initial priming dose of chloromycetin of 50 mg/kilo was given followed by 250 mg. every 2 hours for 48 hours or until the temperature was normal, then 250 mg. every 3-4 hours for 4 to 6 days and finally 250 mg. every 6 to 8 hours for an additional 2 to 3 days. In the second schedule for the remaining patients the initial priming dose was omitted and a dosage of 250 mg. every 3 to 4 hours was given for 4 to 6 days followed with a six hour interval dosage of 250 mg. for 3 to 6 days. Total chloromycetin administered varied from 6 to 22 grams, the average being 12 to 14 grams over a 10 day period. The response of the

patients in each schedule was essentially the same with temperatures, which ranged from 102 to 104 F., falling to normal by lysis in 12 to 72 hours. More recently Woodward⁵ has reported use of cortisone with chloromycetin and patients with typhoid became afebrile in an average of 15.5 hours. Cortisone alone was used in the treatment of 6 patients, but Woodward concluded that chloromycetin should also be used because of its important antibacterial action.

Conclusions:

1. Seven patients suffering from typhoid fever were successfully treated with chloromycetin.
2. Chloromycetin appears to be specific for typhoid fever, but adequate initial dosage of chloromycetin should be administered for prompt lysis of fever.
3. No complications occurred, and stool cultures became negative after the third day of treatment with chloromycetin.

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THE BASIC CONCEPTS OF ALLERGIC DISEASE

ELLISON RICHARDS COOK, III, M.D.

Savannah

An allergic situation seems to frequently precipitate an unfortunate reaction of fear and lack of assurance on the part of many clinicians, resulting sometimes in hasty and ill-conceived symptomatic types of therapy. These may not abate the process, may confuse or accentuate it and, worse, predisposes to recurrences. This communication is an attempt to remind fellow practitioners of simple facts they already know and thus to improve the basic treatment of the simpler

acute allergic reactions.

While the intrinsic chemistry and pathologic physiology concerned possess ramifications that possibly underlie all the organism's reactions to stress, and are enchanting from a deep investigative and physiologic point of view, the facts available on a clinical level are few and simple, but very useful. The diseases in this field we are most often called upon to treat, and therefore the most important are asthma, hay fever, and urticaria. It will be noted that these all consist of acute whealing re-

actions. Thus if this one process and its ramifications are adequately understood and managed there will be left as clinical allergic problems only those relatively few cases of delayed reactions and involved antigen-antibody immunologic situations.

We have seen urticarial wheals, so we know at least what the pathologic picture involved looks like grossly. In hay fever the wheal is on the nasal, and in asthma on the bronchiolar mucus membrane. This process, whenever found, may be considered to be due to local release of histamine. The best antagonist to histamine action yet found is epinephrine, and its best effects are seen from doses less than 0.3 cc. subcutaneously. Most cases of so-called "adrenalin-fastness" are simply the pharmacologic effects to be expected from adrenalin overdosage, and smaller more frequent administration may be found to be effective where a large dose is not.

The effectiveness of the newer synthetic antihistamine drugs is attested to by their number, variety, and advertising budget. They have the advantage of undoubted protective effects and of oral dosage, hence easy availability and self-medication early in an attack. Their disadvantages are great individual and type variability, occasional uncomfortable side effects, and an unfounded tendency to promote complete reliance on a single agent. Parenthetically, it might be mentioned that the wheal has not been seen as the basic pathology of the common cold.

Unfortunately, except in the early stages of the first attacks, the wheal is complicated by other irritative pathologic changes. After the first few hours of an acute asthmatic attack we are dealing with a widespread edematous obstructive lesion at the bronchiolar level, and treatment is accordingly different, i.e., expectorants and removal of mucus plugs. The most useful drug is potassium iodide, which has a less well under-

stood specific effect in addition to its well known expectorant properties. Ephedrine is almost routinely useful. Oxygen is a drying agent, and might delay resolution, so when cyanosis necessitates its use, it must be cautious. Carbon dioxide, on the other hand, is an excellent expectorant, and is frequently sufficiently irritating to promote the deep cough necessary to dislodge inspissated mucus. Since bronchiolar spasm plays a minor role in this condition, the frequently observed temporary beneficial action of aminophylline cannot be ascribed to spasmolysis and must be due to shift of edema fluid by diuretic action, or more likely by increased effective blood flow at the involved area. In spite of warnings of danger, intravenous aminophylline has not to my knowledge been known to have caused the death of an asthmatic, and should therefore be given in its most effective manner, intravenously and rather speedily, since when given in infusions, intramuscularly or orally, its effect is usually inapparent. Emetics, such as apomorphine and ipecac, have frequently aided the termination of wheezing by their associated expectorant effects, and vomiting induced from any other cause may be just as effective. Hydration is necessary, and is best accomplished locally by increasing the humidity of inspired air, and occasionally intravenous fluids are desirable. Anxiety is a natural accompaniment of severe dyspnea and must be allayed by whatever sedatives and attitudes seem necessary in the individual case.

In the case of nasal mucus membrane whealing, or hay fever, frequently recurring attacks may cause progressive increase in depth of a local area, or edematous polyps. Operative removal of these grapelike processes has no effect on the basic processes involved, and may actually increase irritation and thus make symptoms worse. Of course, polyposis to the extent of obstruction

should be removed for comfort, but hope for the relief of the basic process by this procedure is in vain. Similar self-deception may be practiced by local instillation of sympathaco-mimetic nose drops, the immediate effect of which is temporary decongestion, thus a variable measure of symptomatic relief. Unfortunately, due to inherent irritative effects, frequent lack of adequate buffering and isotonicity, and rebound vasodilatation, the net effect is perpetuation of mucus membrane irritation. Actually, symptoms barely distinguishable from true allergic rhinitis can be relieved by cessation of use of intranasal medication. Paranasal sinuses may be blocked by whealing edema about an ostium, or damming behind a polypoid projection, and subsequent stasis and possible infection may further add to the intricacies of the basic hay fever. These must be treated surgically as indicated, but interpretation of indications must be tempered by the knowledge that local manipulation increases traumatized tissue, thus tending to perpetuate itself, and that adequate allergic treatment may decrease blockage and increase drainage. The frequently experienced difficulty in differentiating between hay fever and an upper respiratory infection may be allayed somewhat by examining a direct nasal smear for eosinophiles.

Urticaria is of several types and, though the basic lesion remains the same, some cases present a more involved situation, especially as regards circulating antibodies and localization of lesions. Though an analogous situation probably occurs in a hay fever and asthma it is more apparent that skin lesions appear in areas of trauma and that even mild trauma, such as scratching, tend to perpetuate lesions in the same area. This leads naturally to the clinical impressions that any adjunctive measure which minimizes skin sensation, such as itching,

will greatly augment the effectiveness of adrenalin and/or synthetic antihistamines. Such an anesthetic effect is found in procaine used intravenously. In addition, it has itself antihistaminic properties. Unfortunately its duration of action is short and each subsequent infusion seems to have less effect. Its margin of safety is apparently adequate, so it may be logical to use a greater concentration and at greater speed than usually prescribed. The antihistamines themselves have skin anesthetic effects. Here again the anxiety factor is important, for there can be nothing more nervewrecking than constant unrelieved itching all over.

There was promise at the recent beginning of our hormonal therapeutic era that our allergic problems would cease to be. ACTH remains the treatment of choice for status asthmaticus (which term implies that all else has failed). ACTH and cortisone are frequently of great help in the course of hay fever and urticaria. But these agents do no more than what is claimed for them—to raise the body's general defenses as long as administered. If we are dealing with a recurrent process, as we generally are in this group, amelioration or cure of this attack has no effect on the next one.

The only consistently logical approach to the preventive therapy of allergic manifestations has been the demonstration and management of specific extrinsic antigenic substances. This phase of the subject has frequently been made to seem much more complicated than it need be for the usual case, with the result that it has been either neglected or overemphasized. Briefly, the facts may be summarized with little loss of accuracy: History of contact chronologically related to the onset of symptoms is of infinitely more importance than demonstration of positive skin tests. This is of especial importance in relation to foods, which are

extremely rare as causative factors in hay-fever and asthma in adults. Pollens must be in the air to be inspired in order to cause the symptoms. These are by nature conveniently divided into seasons, viz: trees in the spring, grasses in the summer, and ragweed in the fall. In our locality, however, none of these is prominent antigenically. We find the offender in greater than 90 per cent of the cases to be simple house dust. This is a complex protein, the chemical formulation of which remains to be elucidated, but which is definitely a degradation product of animal and vegetable fibers, chiefly wool, cotton, and feathers. It is naturally found in mattresses, pillows, rugs, upholstery, drapes, and attics. One would come into closer contact with it when shut in by cold or damp weather. Attacks due to it begin typically after going to bed, after sweeping, going into an attic, or with an upper respiratory infection.

The diagnosis of dust or other pollen sensitivity is made historically but confirmation is made by skin test. This is easiest and most reliably performed by application of a solution of the suspected offender to a small scratch on the forearm. Treatment consists of frequent subcutaneous injection of the offending substance, beginning with very small dilution and gradually increasing to tolerance over a period of months. Results are most gratifying, even though a graded series of injections may have to be repeated after a year or so. It must be said in fairness that there are no comparable series of untreated cases so that how far we exceed the spontaneous remission rate is mere conjecture. But even were this a pure psychic phenomenon the satisfaction obtained justifies the continuance of the method.

From the practical standpoint, I would suggest that anyone who faces this class of patients obtain stock solutions of house dust,

ragweed, pecan, timothy, and sycamore. From these confirmatory scratch tests can be done, and dilutions prepared for treatment.

It must be emphasized that in allergies as in any disease process, the patient must be considered as an individual and his disease as the only one of its kind. In an attempt to disclaim stereotyped procedure two examples are mentioned: There is a type of asthma which has its inception in late middle age, which is slowly progressive and intractable to usual methods of treatment. This has been characterized by some as intrinsic, or bacterial asthma. Proof of the bacterial relationship is lacking. A few of these have been found to have polyarteritis nodosa, and possibly many of them do. But the fact remains that many of these people have constant disabling asthma, become debilitated, and rather soon die, if not as a result of this disease at least with this disease as a major contributing factor. And our present state of allergic knowledge remains powerless to explain or to contribute a great deal to their comfort or longevity.

Then there is a group of people who live south of the Mason and Dixon line who are consistently bothered with hay fever symptoms in the summer, and who are not clinically or by skin or laboratory tests sensitive to the seasonal pollens. Luckily, they almost all are relieved by antihistamine drugs, but the allergic nature of their disease remains unknown.

We are extremely fortunate that processes manifesting themselves as allergic diseases are so often so easy to elucidate, and that if the proper procedures are followed the overwhelming majority of them will rather quickly and easily respond to treatment.

NOTE: Discussion of papers by Drs. Mullins and Bonner, and Dr. Cook will appear in a subsequent number of THE JOURNAL.—Ed.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

WHY A STATE MENTAL HYGIENE PROGRAM

GUY V. RICE, M.D.*

and

CARL A. WHITAKER, M.D.**

Atlanta

The citizens of Georgia have for several years been expressing concern about the problems which are generally grouped in the area of mental hygiene. In Georgia, as well as throughout the nation there has been concern over our educational system. There have been strenuous efforts to establish child guidance clinics, to humanize court systems, and to improve the living conditions of the indigent. All of this seems confusing until one has some definition of the term mental hygiene. One could be specific and say that it has to do with helping individuals to be more comfortable within themselves, more comfortable with those about them and more productive in their activities. One could be more accurate and say mental hygiene has to do with increasing the resistance of persons or communities to stresses which they face, whether this stress be physical, social, occupational or emotional. Seen in this framework, it is obvious that mental hygiene stands in the same relationship to psychiatry that public health does to medicine. Each utilizes the findings of the more basic science, but is concerned with its application to the community at large. Mental hygiene at present is a vague entity, but since it concerns itself with the community at large, its orientation is similar to that of public health. Historically we know the development of public health was slow and groping until medicine had itself become a more mature science. The development of community programs in public health in the mental hygiene area will also be slow and groping since it must follow the development of the science of psychiatry. It is even more diffuse because it must develop within the community and because it is not a specifically patient-oriented job and thereby lacks much of the specificity of the doctor's treatment of an individual patient. Thus the problem of developing mental hygiene is that of developing a program in public health. We may remember that there was a long period between the discovery of the typhoid bacillus and the development of public health measures to eliminate typhoid as a disease, even though this latter was quite distinct from the treatment of an individual patient with typhoid fever.

At the present time we can talk about the mental health of an individual and the possibility

of altering it by a personal experience. It is possible also to talk about the mental health of a community and the possibility of bettering it, by activating already existing group forces which make for the development of an increased immunity on the part of the individual and of the group to the inevitable stresses of living. At this point in the growth of our culture we have little understanding of what makes one city have a divorce rate one-half that of an apparently comparable city. We cannot yet measure the vectors which make the delinquency rate in one city drop over a period of a few years.

Efforts have been made to prove that certain types of education or propaganda may be effective in bettering mental health, but to date it seems that personal contact is required for real effectiveness.

What is the responsibility of a doctor in Georgia to a state mental hygiene program? Why should he concern himself with this problem in group living and with the resistance to stress of the individuals in his community? The most obvious answer is that he is a citizen. Further, that because of his position in his community, he is forced to accept certain responsibilities for the mental health of the community in the same way he must accept certain responsibilities for the physical health of the community. These are in addition to the obvious mental health activities which he has been carrying on in his regular medical practice. Although each physician has accepted his responsibility to his individual patient, responsibility to the community is something which he must work out for himself. Potentially, he has much to give, and in the giving much to gain, both as a person and as a physician.

Probably as much or more than any one else in the community, the physician has learned much about stress and its effect on individuals; thereby he should be a leader in the development within the community of an increasing push toward the attainment of mental health goals. More specifically, the physician is one of the few people in the community who has learned what tremendous capacity individuals can develop for immunity to stress, whether it be against a bacterium or a social or physical handicap. He should be one of those who has the courage to demand of the community that it do something about its ills, whether they be

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THE GEORGIA PLAN

Recently it was announced that President Truman would come out with a plan to provide free hospitalization for all on Social Security rolls who are over 65 years of age.

"This new development in the long fight for some form of universal sickness insurance . . . was disclosed as the result of a series of preliminary conferences on the subject with nongovernmental leaders," an item in *The Atlanta Constitution* stated.

Federal Security Administrator Oscar Ewing is the promulgator of the new plan, the article went on to say, and it could become an important factor in the next political campaign.

Having failed, for the present at least, to socialize all of medicine, this new plan could be the entering wedge that might break the dam. One way or the other, Ewing and his Welfare State cohorts are going to perpetuate their hold on the purse-strings of the treasury if at all possible.

At times, it seems that this fetish for economic planning—this dream of cradle to the grave security and prosperity for all will eventually win out and submerge us all under the dead hand of Socialism. It may unless each and every one of us do our part to block it.

One of the most positive weapons that we, of the medical profession, have with which to fight the encroachment of Socialism is the promotion of voluntary, prepayment health insurance. Our surgical and obstetrical insurance plan, The Georgia Plan, can do much to quiet some of the outcry against "the ruinous cost of medical care," but we all must support it—lip service, alone, is not sufficient.

It is not enough to have established the plan and agreed to its provisions, we must make an effort to see that everyone benefits from it.

The Georgia Plan is gaining rapid acceptance by the insurance companies and the public.

Twenty-one insurance companies are now offering The Georgia Plan to the public and 80 per

cent of the doctors of Georgia have agreed to participate. It is expected that at least twice as many companies will eventually underwrite the Plan, in connection with hospitalization and medical insurance, and it is hoped that 100 per cent of the doctors, in active practice, will be participants.

The new Georgia Plan booklet which fully explains the program and contains the names of supporting doctors and underwriting agencies is in the hands of the printers now and will be ready for public distribution shortly.

Active support of The Georgia Plan is one of the most effective answers the medical profession and insurance companies can give to "socialized medicine."

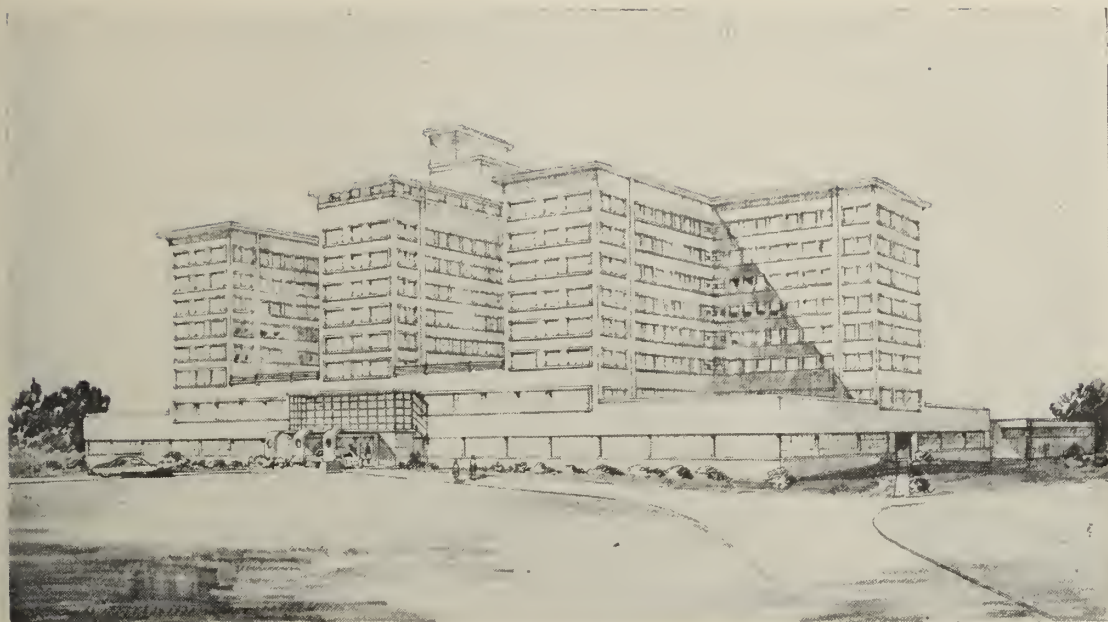
RICHARD J. EALES

We regret to announce that Mr. Eales, our Executive Secretary in charge of Public Relations, is leaving us on June 15 to accept a position with the Life Insurance Association of America in New York City. It is our understanding that part of his duties will be to coordinate the insurance activities of state medical associations and the insurance industry and we feel that in this capacity he will continue to work for the good of the medical profession.

Mr. Eales came to us only last August and during this short stay with the Medical Association he has made many friends among the doctors and persons allied with the medical profession. He has done much to create a better understanding between the doctors and the press and was instrumental in establishing the "Code of Cooperation" for the medical profession and press and radio of Fulton County. The First Annual Press and Radio Conference, staged by Mr. Eales in February was a tremendous success. Under the guidance of the Public Relations Committee he has done much to inform and educate the public about medical care and to help the doctors realize their responsibilities to their profession as well as to the public. The success of The Georgia Plan of surgical insurance is due, in a large part, to his untiring efforts in its behalf.

Although born in Indiana, Mr. Eales had lived in Illinois, where he received most of his education at Bradley and Northwestern. He served with distinction in World War II being separated with the rank of Captain. He is married to an attractive Atlantian and they have one son.

The Medical Association of Georgia takes this opportunity to express our appreciation to Mr. Eales for this splendid progress that he made in Public Relations work for us, and we wish him happiness and success in his new position.



Architect's drawing of the proposed new State General Hospital, Augusta (1951).

THE NEW STATE GENERAL HOSPITAL

TO BE CONSTRUCTED IN AUGUSTA

Early in September of 1950, Governor Herman E. Talmadge called together representatives of the State Board of Regents, the State Board of Public Health and the Medical College of Georgia to discuss the need for and preliminary planning relative to a State General Hospital. This group was to serve as an advisory planning committee to the Governor and was to prepare for him preliminary recommendations regarding the State General Hospital.

The need for increased facilities for clinical instruction at the Medical College of Georgia had been recognized for many years, had been stressed by members of the survey committee of the American Medical Association, who are keenly interested in the plans for development of a medical center in connection with the Medical College of Georgia.

Immediately following the conference with the Governor and at frequent intervals during the remainder of 1950, the Governor's planning committee met several times. There were also numerous informal conferences or discussions relative to the proposed State Hospital. An important point brought out in one of these discussions was that the State Board of Regents did not wish to accept the responsibility involved in the construction and operation of a State General Hospital. It may be that at some future date that the Board of Regents or a Governing Board will take over the operation of this hospital.

At a meeting of the State Board of Health on

January 3, 1951, at which Dr. G. Lombard Kelly, President of the Medical College of Georgia, and the Legislative and Policy Committee of the Medical Association of Georgia were present, there was discussion of the State General Hospital with particular emphasis relative to whether or not the State Board of Health should serve as governing body of this facility. It was agreed that the State Board of Health was the most logical established agency to assume this responsibility even though the State Board of Health did not seek the task of constructing and operating the State general hospital, but to do so only to make possible the fruition of the plans of long years. The State Board of Health adopted a resolution indicating willingness to undertake the construction and operation of the State General Hospital provided this was acceptable to the Medical Association of Georgia.

Following this action the General Assembly of the State Legislature passed a bill authorizing the State Board of Health to construct and operate a State General Hospital and this Act was approved by the Governor on Feb. 21, 1951.

Between January 3, 1951 and March 6, 1951, the Secretary of the Medical Association of Georgia distributed copies of the resolution adopted by the State Board of Health in the called meeting of January 3, 1951 to the members of the Council of the Association and asked that their views be expressed by proxy vote. The resolution was approved by the Council of the State Association with only one negative vote.

With this endorsement by the Medical Association of Georgia the State Board of Health, in a called meeting on March 6, 1951, adopted resolutions directing the Georgia Department of Public Health to proceed with the planning for the project, including the execution of working agreements with the designated architects, and the medical consultant. Greggson and Ellis of Atlanta were selected as architects with Dr. Herman Smith of Chicago as the medical consultant and the plans for the hospital are being developed in cooperation with the staff of the Medical College of Georgia.

The State General Hospital that is to be erected at Augusta will provide the additional teaching, research and related facilities that are needed for the Medical College of Georgia. The erection of this hospital is to serve a dual purpose—to increase facilities for instruction of medical students and to provide a general hospital to serve the indigent sick of the State. Obviously, a hospital of 678 beds cannot assume the entire burden of providing care for the sick indigents throughout the State so that cities and counties must continue to provide care for these patients within the means available.

The completion of the plans for the new hospital are being pushed to completion and it is hoped that the construction may be finished within the next three years. This new hospital will enable the Medical College of Georgia to increase its enrollment to approximately 100 students in each class.

R. C. WILLIAMS, M.D., *Director*
Division of Hospital Services
Georgia Department of Public
Health.

WHY A STATE MENTAL HYGIENE PROGRAM

(Continued from Page 259)

physical or mental. Furthermore, the physician with his background in scientific training can be the person in the community whose understandings and insights could well result in discoveries of importance to the over-all field of mental hygiene, to date almost unexplored. We have been talking about the doctor's responsibility. It must be obvious that the doctor who is able to loose his professional isolation by such involvement in the community may well discover that this is one place where he can be an individual as well as a physician and thereby contribute to his own mental health.

Where does the State Department of Public Health fit into the over-all development of a science of mental hygiene? Public health has a responsibility to point to its own past accomplishments in the betterment of community health, as an indication of what can be accomplished and as a demand upon the community to go to work on the present problem. Public

health has the responsibility for finding the persons, the groups and the concepts which will lead the community towards good mental health and help the community get behind these to increase their significance and their value. It has the contrasting responsibility of helping the community discover those things which will impair its mental health in the same sense that it had the responsibility for pointing out those things which impaired its public health. It has also two areas in which it can contribute by functioning at the state level: one, the facilitation of over-all research projects and second, the development of long range planning.

Thus, the community, the physician and the health department have both the responsibility and the opportunity for the development of a state mental hygiene program.

OHIO JOURNAL PRAISES PROGRAM OF AMA IN REPRESENTING M.D.'s

"The Journal of the Ohio State Medical Association says:

"The A.M.A. has many activities. . . . It has spent more than a million dollars for medical research in the past few years. . . . The Association has spent approximately a quarter of a million dollars a year for many years past to advance medical education through its Council on Medical Education and Hospitals and other departments. . . . Its Judicial Council. Councils on Scientific Assembly, Medical Service, Pharmacy and Chemistry, Physical Medicine and Rehabilitation, Foods and Nutrition. Industrial Health, National Emergency Medical Service, its various Bureaus, Committees and Sections have been active in constructive programs in rural health, school health, in the publication of numerous scientific journals and in many other phases of activity.

Representative

"The A.M.A. is the only organization which can properly represent the opinions and interests of the physicians of America. . . . Few will contest the propriety of the objectives of the A.M.A. and the similarity of interests of the physicians and the people of America. . . . In any vigorous growth rooted in democracy all functions and decisions will not satisfy all constituents. Policies of the parent organization will often be at variance with viewpoints of certain state organizations and even more often with viewpoints of individuals.

"The decision to withhold or withdraw support or to resign membership should be carefully considered. . . . American medicine is passing through a most critical period. The active participation of every physician in America is needed to guide the policies of the changing order in the direction best suited to the best interests of the public and of the medical profession."

ORGANIZATION SECTION

PROCEEDINGS OF THE HOUSE OF DELEGATES, 101st ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA, HELD IN AUGUSTA, APRIL 17-20, 1951

First Meeting—Tuesday Afternoon, April 17

The House of Delegates of the Medical Association of Georgia, meeting in conjunction with the 101st annual session of the Association, at the Bon Air Hotel, Augusta, convened at 2:30 p.m., Dr. A. M. Phillips, President, presiding.

Roll Call by Secretary

Reference Committees Named:

- No. 1. Ralph H. Chaney, Chairman, Augusta
George H. Alexander, Forsyth
Ben K. Looper, Canton
- No. 2. T. F. Sellers, Chairman, Atlanta
Albert R. Bush, Hawkinsville
David R. Thomas, Jr., Augusta
- No. 3. W. L. Pomeroy, Chairman, Waycross
Fred H. Simonton, Chickamauga
John L. Elliott, Savannah

Report of President, Dr. A. M. Phillips

With Dr. C. K. Sharp, Arlington, past president in the chair the President presented the following report:

During the past year it has been my pleasure to visit with most of the district societies over our state. Also, out of the state meetings have been attended and I have traveled a total of 12,605 miles during my term of office on official business of the Association.

The theme of my talk to each group has been more or less along the line that is—Closer cooperation among the doctors and a plea for the unselfish support in our efforts to combat socialized medicine and a request for whole-hearted help in the work being done by our Public Relations Department.

Not only the district societies were visited but some county societies as well. This official duty as your president has been a distinct pleasure.

Other visitations made during the year have included sectional meetings of the Better Health Conference of the Citizen's Council, many civic and professional groups. Whenever possible, I have tried to give a true picture of medical practice as it should be and attempt to explain the interest we, as doctors, have in the welfare of the patient.

Your Committee on Public Policy and Legislation has been most active. Under the chairmanship of Dr. C. C. Aven this committee has performed all the duties that could have been expected of it and has also worked in close cooperation with the Public Relations Department. This is as it should be since matters of the committee on Public Policy and Legislation are naturally the concern of the Department of Public Relations. Dr. Aven has performed his task admirably and I am very grateful.

The Woman's Auxiliary

During my term of office, the Woman's Auxiliary to the Medical Association of Georgia has been most active. The work done by this organization has been most gratifying. I am sincere when I say that the wives of the doctors of Georgia are doing a bigger and better job than they are being given credit for. Unless one has a direct contact with the auxiliary, it is difficult to realize the amount of effort being expended by them on our behalf. For their unsolicited help and their untiring efforts on behalf of the doctors, I have one recommendation to make to this Association and I trust that due consideration of this request will be

accorded. Your Advisory Committee to the Woman's Auxiliary has worked in close cooperation with the auxiliary and I appreciate their efforts greatly.

Committee On Industrial Health

Your committee on Industrial Health has done a splendid job this year. It was due to the efforts of this committee and the committee from the State Board of Health that the sectional meeting of the Congress on Industrial Health of the American Medical Association was held in Atlanta in February of this year. The chairman of the Committee on Industrial Health of the A.M.A. wrote me a very complimentary letter regarding the meeting and expressed his sincere appreciation for the cooperation of the Medical Association of Georgia. He expressed hope that it would be their pleasure to meet again in Georgia at a not too distant future date. The presentation by Dr. Petrie of our own State Board of Health was well received and deserves commendation.

Prepayment Medical Care Plan or the Georgia Plan

During the past year, this committee, under the chairmanship of Dr. W. S. Dorrough, has been one of the most active and untiring in its efforts. A plan has been formulated, presented and accepted by the membership of the association. The primary object was to formulate an acceptable plan that would be of benefit to the low income group of patients and at the same time indirectly help the physicians.

Public Relations Department

As all of you know, at the beginning of my term of office, the Department of Public Relations was at a very low ebb. In spite of the fact that the department had been opened at the beginning of the term of office of my predecessor, Dr. Enoch Callaway, and had functioned in a satisfactory manner, it was the will of the Association that the department be re-organized and begin anew. Under the chairmanship of Dr. Steve Brown, the office was re-opened and shortly thereafter Mr. Richard Eales was employed as director. During the past year a great deal of progress has been made in spite of handicaps that had to be overcome. There have been times when we thought that the office would have to be closed for lack of available funds but somehow the problems have been worked out.

It is my hope that this department will be continued next year. The work done this year is most commendable and Dr. Steve Brown and Dr. C. C. Aven have worked diligently and are responsible for the progress that has been made. Mr. Richard Eales and his secretary, Miss Dene Johnson, deserve the commendations of this Association.

Committee on Revision of the Constitution and By-Laws

In 1949, a committee on the Revision of the Constitution and By-Laws was appointed. This committee did a great deal of work and it was recommended that this work be continued and that a new committee be appointed. This committee has met several times during the past year and the results of the work done is shown in the pamphlet that is being given to each member of the Association. Dr. Bunce and his committee have done a fine piece of work and the Association should recognize this fact.

Work With Officers and Council

During this year it has been a pleasure to be associated with and work with the officers and members of Council. Your President-Elect was most active and cooperative. I am sure that he will be an asset to the Association and prove to be a great leader during his term of office. Your Vice-Presidents have been most willing in whatever they were called upon to do. My work with Council has been most pleasant. I have received the fullest cooperation of every member of Council and they have been a great help.

During the year, your Secretary was quite ill and consequently the Association was handicapped. However, the Executive Secretary, Miss Viola Berry, did a good job and the office carried on as usual.

For all the cooperation that I have received from the officers and members of Council, I am grateful.

Committee On Group Insurance

Your Committee on Group Insurance headed by Dr. John W. Turner has functioned in a very satisfactory manner, and the report will be of interest.

Committee On Scientific Work

The work of this committee is very important since your program is the result of its efforts. Under the chairmanship of Dr. W. C. McGeary this committee has done a good job in preparing this year's program.

Medical Civilian Preparedness

We hear very little of this committee due to the fact that all their plans are in the making although I have been informed regularly as to its activities. This committee, headed by Dr. Edgar M. Dunstan, has been most active and is one of our most important.

Other Committees

All of the other committees of the Association have functioned very nicely. I have kept in contact with the chairman of each committee and I wish to express my appreciation for the work that has been done.

Conclusions reached after one year's service:

In all of my contacts with members of this Association, I have received a most cordial welcome and my ideas were in accord with those of most of our membership. There still seems to be a lack of enthusiasm on the part of some of the members in trying to do their individual share of work towards combatting compulsory health insurance. I hope that this will be remedied.

In practically all of our undertakings we have made progress and I have no regrets to express at not having accomplished more. We still have a long way to go but we are making progress and I am certain that we shall continue to go forward.

Recommendations for the Coming Year

1. That the duties of the officers of the Association be re-defined. Not on account of there being any doubt as to what these duties are because they are clearly outlined in the Constitution and By-Laws. These duties should be brought to the attention of all officers and should be re-emphasized.

2. That the Woman's Auxiliary be aided financially to the extent of \$600 to establish a Bulletin to be published for the benefit of its membership.

3. That the Public Relations Department be continued as it is now being operated with the exception of the handlings of its finances. I suggest that the amount of money appropriated to the Public Relations Department be turned over to the department and that checks for expenses incurred by that department be issued by that department, signed by the chairman of the committee on Public Relations, said chairman to be bonded to the extent of financial liability. This

arrangement will save lots of time, work, worry and uncertainty so far as the department is concerned and would bring about a much smoother operation of the Public Relations Department.

4. I further recommend a careful study of the revised Constitution and By-Laws since it is the feeling of your committee that this revision fills the needs of this Association.

5. I suggest and recommend that the president of your Association be given a page each month in The Journal of the Medical Association of Georgia. This page to be utilized by the president in any way that he sees fit. That any message that he may want to send to the doctors of Georgia be published, uncensored. This is a privilege that should be accorded your president since he is supposed to be the head of your organization and enough faith should be placed in him to allow him to express his views.

Thank you again for your cooperation and for the privilege of being your president during the past year.

Report of President-Elect, Dr. W. F. Reavis

It is my personal opinion that the Medical Association of Georgia is in good, sound, healthy condition. We have had several meetings of the Council, at which time there was considerable work done.

The Public Relations program has progressed well during this year. I still think there could be closer contact between the Public Relations Office and the Secretary's Office. This can easily be accomplished.

I think the amended Constitution and By-Laws, as you will note from report of committee, is very sound and there are not too many changes in the old Constitution and By-Laws.

It is my opinion that the House of Delegates should instruct the Scientific Committee, to allow each man giving a paper 15 minutes for presentation and 5 minutes to each man designated to discuss same. This would reduce the number of papers, but should give us a much better program.

We are still over-burdened with committees that have served their purposes and at the present time some of them are not functioning sufficiently to continue same.

Due to the small dues of the Woman's Auxiliary, I think it would be well for the Medical Association of Georgia to appropriate a sum sufficient to pay for printing of their own Bulletin, this sum not to exceed \$600.00, instead of furnishing space in The Journal.

I am begging all of you to give me your heartiest support during the next year and let's make the year for the Medical Association of Georgia a happy and prosperous one.

Report of First Vice-President, Dr. Leon D. Porch

Mr. President and members of the House of Delegates: Under our Constitution the duties of the Vice President are to assist the President. As you learned from the report Dr. Phillips has made, our President last year was very active and left very little for the Vice-President to do.

I have kept myself in readiness and have tried to render whatever assistance I could. I have attended several meetings during the year, and in so far as possible I have spoken in behalf of the work of the Association in my own community.

I was willing to serve, and still am ready to serve. My report, therefore, is very short. Perhaps the last convention gave me more hours of actual work for the Association than any time during the past year.

Report of Parliamentarian, Dr. John W. Simmons

We are living in a rapidly changing world, with multiplying problems as individuals, and extremely

vexing problems as local, state and national medical organizations; but there are a few things which should never change. These are: First, our strict observance of our individual ethical relationships among ourselves and in the presence of our patients and consultants. Second, a firm adherence to our Hippocratic Oath. Third, the highest standards of sobriety and morality that can possibly be attained by mankind, as true representatives of what Robert Louis Stevenson has called the noblest and highest profession or calling on earth.

Your parliamentarian may live to see at this session, or the next, I hope, the carrying out of recommendations he has been making for years in his annual reports. Among these are the abolition of this obsolete office; the proper revision of your Constitution and By-Laws, with the proper classification of the various laws, rules and regulation of procedures; the proper grouping and separation of the various functions of your various committees, officers and employees, both professional and laymen. But, in the "streamlining" and modernization, beware of ideologies and trends, extravagancies, and undemocratic frameworks that are wrecking our national government to some extent, and creating obli-garchies among labor and other nationwide organizations interfering with individual rights and liberties or actions.

Wisdom is not always the characteristic of age; but experience, connected with "I remember when" is certainly needed now, when the nation has 35,000,000 "problem children" who knew nothing prior to our present trends in governments and labor, as well as industry. In short, let us conduct ourselves and our organizations in all matters relating to both ourselves as individuals and the public at large in such a manner that is above reproach or criticism.

Do not say, "It can't be done." Only the selfish say that. There must be those who can remember the time when "it was done," at least by the vast majority of the profession we represent. It can be done again if "cocktail party" caucuses and convocations are abandoned, and we meet with minds unbefuddled, seeking to find the best of everything for everyone in our profession, forgetting our individual likes and dislikes, our individual greed and prosperity.

Rumors predict "stormy weather" in our deliberations. Your parliamentarian has tried to analyze most of these rumors and objections; these disappointments over comparatively low surgical and obstetrical fees in your new insurance fees; some of the proposed multiplication and divisions of administrative and other officers. Let us calmly and in the spirit of compromise and brotherly love discuss some of these questions, and, forgetting our own personal interests, whether pecuniary or honorary, whether with, or without, reward of any kind, reach conclusions that will be for the best interests and advantage of the greatest number of us.

Having noted for years the average increases of annual income of the profession at large as published even some years ago, I can readily understand some of the criticism directed against us as a national organization by The American Federation of Labor, though I think it is unwarranted and often unjust when every one of our AMA members are included in the chastisement.

Please do not consider the remarks I have made as the carping and griping of a garrulous old man. Far from that they are. I believe in the slogan, "If you love me tell me now." I do love every member of this Association whom I know personally. I am moving toward the sunset too fast to do otherwise, and remember far more seeing the gorgeous multi-colored skies of a glorious sunset than ever witness Old Sol peeping over the horizon at dawn. Thank you.

Report of Secretary-Treasurer Dr. Edgar D. Shanks

For the calendar year of 1950, we had 2,279 members in the Association. Up to April 14, 1950, 1,893 members had been reported to my office, whereas this year, one year and three days later, 1,888 members have been reported, a difference of only five. That is rather remarkable.

When I became Secretary I think Dr. Bunce had a roll of 1,681 members. Today we have 2,279. That shows an increased interest in the affairs of the Association.

On March 31, 1951 the Association had assets and cash in the amount of \$112,230.57. In the general fund we had \$43,383.77. In the benevolent fund we had \$25,000, and in the building fund \$35,000. That money was earmarked some years ago for those funds.

The Abner Wellborn Calhoun Lectureship fund, which was made a permanent fund of the Association at the Augusta meeting in 1947, amounts to \$5,526.20.

The difference between the previous audit and this audit is only \$1,136.34, which shows also consistency in the matter of finances.

The Council of the Association is the financial body, and each councilor later on in the day will receive a copy of this financial report for study and recommendations.

Last year only 1,324 of our members paid their \$25 dues to the American Medical Association. This year I think it has improved somewhat.

Since April 1, 1950 we have sent to the American Medical Association \$45,180.50.

Report of A.M.A. Delegates, Dr. C. H. Richardson, Dr. Allen H. Bunce, and Dr. B. H. Minchew

San Francisco Meeting

The speaker, Dr. F. F. Borzell, made a very forceful address, including suggestion that the House of Delegates authorize an interim committee on Constitution and By-Laws be amended to make this a permanent standing committee. This action was taken by the House.

Next on the program was the address of the president, Dr. Ernest E. Irons, who gave a very forceful exposition of our medical and economic problems, and stated that medicine will flourish and progress only in a sound economy, and that to socialize medicine is to socialize America.

The Board of Trustees made a financial statement showing that the voluntary assessment placed on its members by the House of Delegates for the year 1949 had amounted to \$2,289,958.23, and that disbursements from this fund in the conduct of the National Educational Campaign amounted to \$1,613,812.78.

The Committee on General Practitioners made a very interesting report to the House of Delegates and noted that the American Academy of General Practitioners had obtained a membership of approximately 12,000. It was shown that a well balanced medical community could be established with a foundation of 60 to 80 per cent of well trained general practitioners, and it was suggested that they be included as clinical instructors in the medical schools and give lectures on the art of medical practice in the junior and senior years, and that general practitioner residencies and internships be established in hospitals.

The Board of Trustees offered resolutions in opposition the reorganization plan No. 27 of the federal government which would place a layman as director of health and welfare agencies of the government with cabinet status.

Under the head of new business, Dr. Allen Bunce introduced a resolution of sympathy to Dr. and Mrs. James E. Paullin who had been injured in an automobile accident just before this meeting. This was unanimously carried.

Dr. Bunce offered another resolution for the Georgia Delegation which was sponsored by the Fulton County Medical Society and which was in opposition to complete medical care for non-service connected disabilities by the V.A. This was later accepted in principle and the House felt that it was covered by another action.

A very interesting resolution by Dr. William F. Costello of New Jersey offered a twelve point program known as the New Jersey Plan in an effort to state the position of the Association on medical care for the low income groups, but it was not adopted at this meeting.

An extensive survey of medical education and medical practice in Great Britain was reported by two committees and these are being published in the Journal of the American Medical Association and contains much useful information.

There was much discussion of a supplementary report of the Board of Trustees in reference to a physician disposing of his professional attainments or services in any hospital, corporation or lay body under terms or conditions which permit the sale of services of that physician by such agency for a fee. This has formerly been covered in the Hess Report and no action was taken on it at this meeting.

The Committee on Legislation and Public Relations made a study of the financial problems of private and state supported medical schools and went on record as opposed to government grants to these schools on the basis of the broad general principle that the government may regulate that which it subsidizes.

The Committee on Veterans Affairs went on record as stating that veterans entitled to medical care for non-service connected disabilities as defined by the Congress should be cared for by existing civilian facilities.

The last two actions taken by the House of Delegates at this meeting were the election of officers, and selection of a meeting place for the annual session in 1953. New York City was selected for the meeting place of the annual session in 1953.

At this meeting, out of 198 delegates, 195 answered to their names.

Cleveland Meeting

The Association was represented by Doctors Bunce, Richardson and Minchew.

The first order of business was the election of Dr. Dean Sherwood Luce of Canton, Mass., as the outstanding general practitioner of the year.

The address of the speaker was followed by a forceful address by the President, Dr. Elmer L. Henderson, who discussed particularly the question of financial support of medical education and the position of the American Medical Association with respect to the program of hospital standardization. It was reported that the American College of Surgeons had agreed to continue its program of hospital standardization, and that a program would be developed in which the American Medical Association, The American Hospital Association and the American College of Surgeons will participate.

The next order of business was the report of the Secretary, Dr. Lull, and he showed that the membership roster carried the names of 145,036 physicians in 1949 and in 1950 147,725, an increase of 2,689. It was shown that the membership had decreased in the state of Georgia from 2,345 to 2,191, and during this session it was decided that the number of delegates

that a state would have would depend on the paying members of the American Medical Association in its borders on December 31 of the preceding year. This is a matter of great concern to our state Association, as last year we only had 1,400 paying members, and this would cut the number of delegates from three to two.

It was decided at this meeting that the membership dues for 1951 would be \$25.00 and that the Fellowship dues would be \$5.00 in addition to this, and that it is necessary to apply for Fellowship.

The report of the Washington office was very interesting, and brought out the fact that not a single bill opposed by the Association had been enacted by the Congress during the past year.

The report of the Bureau of Legal Medicine and Legislation again condemned the practice of physicians accepting kickbacks from opticians and others.

In a supplementary report, the Board of Trustees discussed the question whether the American Medical Association would modify its stand on federal aid to medical education for the period of the emergency, and in a forceful manner gave its reasons why any such modification would not help the present emergency, as it would take at least four years to put any plan into operation.

The outstanding event of this meeting occurred on Wednesday morning, December 6, when in a supplementary report of the board of Trustees on a fund for aid of medical education, the Chairman, Dr. Louis H. Bauer, announced that the Board of Trustees of the American Medical Association is pleased to announce to the House of Delegates that it has appropriated one half million dollars out of its National Education Campaign Fund, which was raised to defend medical freedom, for the aid and support of medical schools which are in need of additional financing. This announcement not only met with an enthusiastic approval by the House of Delegates, but as soon as it went on the news wires telegrams began to pour in from many bodies associated with medicine, offering to supplement the fund, and every doctor in the American Medical Association will have the opportunity of subscribing to it if he so cares. This was medicine's answer to federal aid for education.

The House adjourned at 12:00 noon on Thursday, December 7, after completing the balance of its routine business.

DR. RICHARDSON (continuing): In conclusion, gentlemen, I would like to make just one or two suggestions, not for action by this body but for you to think about.

One is that when you see how wonderfully the House of Delegates of the American Medical Association functions under what one might call almost a permanent Speaker, it suggests to your mind immediately the fact that any Association would operate better with a Speaker, and that the President of the Association would be free to preside over the scientific sessions and would not be tied up with the work of the House of Delegates.

I have two other thoughts. One is that if any of you have served (as I have in the past year) on this Committee to Revise the Constitution and By-laws, and find what a difficult undertaking it is, it brings up this food for thought: We might also consider a permanent Standing Committee on Constitution and By-laws, so that when changes take place we can make them and study them from time to time, rather than have a committee undertake that work, such as Dr. Bunce's Committee was forced to undertake this year.

The final thought I would leave with you is that: You men should go back to your local societies and really try to whip up a campaign to increase our membership in the American Medical Association. There is no reason in the world why we should not have 2,000 doctors in Georgia as members of the American Medical Association, if we really made an effort. Unless we do, we are going to lose, next year, one of our delegates to the AMA.

Report of Committee on Scientific Work, Dr. W. C. McGeary, chairman

Upon motion of Secretary Shanks, the official program of the Annual Session was adopted as printed.

Report of Committee on Public Policy and Legislation, Dr. C. C. Aven, chairman

Assistance was given to the passage of the bill which provided for the examination and registration of qualified Physical Therapist. We also aided the Legislative Committee of the Georgia Nurses' Association in sponsoring a bill for the training and registration of practical nurses which is now pending. The failure was probably due to the late introduction of the bill and the manner in which it was drawn.

We met with the members of the State Board of Health and discussed the passage of the bill authorizing the State Board of Health to build and operate a State General Hospital at Augusta, Georgia. The urgency of this bill was extreme and a few days delay would probably have meant the loss of this hospital to the State and the Medical College of Georgia, or certainly would have given a great opportunity for political manipulation in the passage of the bill and placed the management in political hands.

Several pieces of legislation that we felt would have been contrary to the interest of organized medicine and the public were defeated. Let me here give credit to several members of this Association that were in the Senate and House, for without their guidance we might have met failure in our efforts.

May our committee suggest to the President each year that he call to the attention of the members in his retiring address such legislation as deemed necessary for our progress and protection of the public. The attorney for the Association might make a study of laws that are obsolete and out of keeping with the present status of our organization and public interest, and suggest any amendments or new laws that are wise.

The chairman wishes to thank one and all of the members of this committee for their services and also others that were helpful to us in our efforts.

DR. AVEN (continuing): I would like to say that when Dr. Sellers and members of the Board of Health called this meeting in Atlanta, there had been an effort made to get the Board of Regents to sponsor the bill and to take over the authorization for the building of this hospital. They did not want it. They did not feel that it was in their domain, and Dr. Norris and Dr. Sellers were the only members of this committee meeting with the State Board of Health. We questioned the advisability of the State Board of Health going into the so-called practice of medicine rather than the preventive field.

Since our Board of Health is really appointed from recommendations submitted by our district societies, and since it was the only non-political body that could take over this authorization and build this hospital without probably getting into deep politics, Dr. Norris and Dr. Sellers and I thought it would be wise for this authority to be given. I believe the Council was questioned by mail, and I think there was practically no vote against the idea.

Report of Advisory Committee to State Board of Health, Dr. Edgar H. Greene

No recommendations.

Report of Committee on Abner Wellborn Calhoun Lectureship, Dr. James E. Paullin, chairman

DR. JAMES E. PAULLIN: Mr. President, the lecturer this year is Dr. Irving S. Wright, of New York City.

Report of Committee on Revision of the Constitution and By-Laws, Dr. Allen H. Bunce, chairman

We have printed our report and will distribute it to you. Please consider this as our proposed revision of the Constitution and By-Laws. We have had 500 copies printed, enough for each member of the Association in attendance.

Report of Committee on Medical History, Dr. J. Calvin Weaver, chairman

As Chairman of the History Committee I hope we can start over with renewed interest and that at least one member from every county of Georgia will make it his business to furnish us all of the main points of medical historical interest pertaining to his county. Let me ask your indulgence of what has been done and what we propose to do.

Before going further with the report, let us decide the question, "Has Medical History Any Value?" I hold strongly to the answer, "It definitely does!" However, I do not expect the younger men who have taken over since World War II to see eye to eye with me. From my observation and experience, I cannot help but notice the difference of attitude of the graduates of 1900 with the present day ones, on which account I must agree with Alexander Wilder in his History of Medicine, who says "The younger ones in a community are eager to exalt themselves by depreciating the attainments and experience of others;" a discouraging attitude so far as history is concerned.

To go further and quote from Joseph L. Miller of Thomas, W. Virginia, "Nothing is more fruitful of evil to our profession than the lack of, or improper, mental culture of those who engage in its pursuit." He also said, "The power, vigor and success of modern medicine has engendered in the rank and file of the profession of today in their ignorance of the past, the narrow and complacent feeling that 'We are the men and knowledge has come with us'."

"A consideration of Medical history shows us that each age stands on the shoulders of those gone before; it gives us a better perspective of modern medicine; a clearer vision of the possibilities of the future." To me, it makes us known that radicalism of today will be conservatism of tomorrow.

William Osler, who dealt as much with the young men of the profession and who worked as hard from the cultural side as any man who ever lived, made the discouraging statement, "Of the altruistic instincts, veneration is not the most highly developed at the present day. It is the sign of a dry age when the great men of the past are held in light esteem."

As to our historical committee we are all in perfect accord. Dr. Allen Bunce has assured me of his hearty cooperation. Dr. Frank Boland has showed his interest by furnishing some valuable data; he has also assured me he has a "trunk full of data" awaiting my call. Dr. Dancy has assured me of his willingness to help, as has Dr. Abercrombie, who is working up the History of Public Health work in Georgia, to which I'm sure we will have access on its completion.

It is with deep regret that Dr. Murphy has notified me that the condition of his health prevents his taking an active part as a committeeman.

It was most unfortunate that Dr. Bassett of Savannah should pass on before the history was completed as he would have been the ideal man to write it. I feel sure the Committee is unanimous in the idea that it is a one-man job; however every member could be of some help as to the material available.

From the committee members we will have from Dr. Frank Boland his article on the history of the Medical Association of Georgia and his book on Crawford W. Long; Dr. Abercrombie will no doubt have finished his study on Public Health in Georgia. There are several articles by Dr. Bassett which will be most helpful: "Plantation Medicine"; "Popular Remedies Used by Southern People"; "Pages from the History of the Georgia Medical Society of Savannah, Georgia"; "Two Physicians and Two Periods in the Medical History of Georgia—Lives of Dr. Joshua Elder White and Dr. Alexander Jones"; "Two Physicians and Two Periods in the Medical History of Georgia—Appendix by Mrs. Bassett" and "The Medical Career of John LeConte, 1818-1891".

A sketch of Dr. Bassett's Life by Dr. Boland; the articles by Dr. Krafka, deceased, as follows: "Medicine in Colonial Georgia"; "Augusta, From Trading Post to Medical Center"; "Quackery in Georgia One Hundred Years Ago"; "Joseph Jones, Surgeon C.S.A."; "Stephens Hales and the Founding of Georgia." Dr. John W. Simmons' of Brunswick, Ga., article "Forty Years of Medicine." And my own article, "Early Medical History of Georgia—Georgia as a Colony."

Your chairman is well on the way towards completing an article on Georgia as a Province. These two articles will carry us from the beginning of Georgia on through the Revolutionary War and to Georgia as a State.

I have also collected from time to time interesting data of a general nature. Dr. Eugene Foster's long and most enlightening article in "Memoirs of Georgia" will stand us in good stead.

It has occurred to me that a chapter citing a list of books written by Georgia doctors with a thumbnail sketch of each author would be interesting and a valuable source of reference for future writers. So far I have collected thirty and with your help we will doubtless be able to add more.

Though the History of Macon, published in the Macon Telegraph several years ago, of which I made a scrapbook, carried nothing of a medical nature, fortunately our Association Journal in April 1941 carried ten original articles devoted to the Medical History of Macon. The History of the Medical College in Augusta, and also of the Savannah College, have been written. I have notes on the Old Botanical Medical College started at Forsyth, Ga., then moved to Macon, Ga., which will be of historical interest.

With the hope of resuscitating an apparently dying interest in medical history, I have gone to considerable trouble and some expense to put on an exhibit of a medical nature at the Partridge Inn, which I hope you will enjoy.

As chairman, all my spare time has been given to medical history. Knowing the uncertainty of life and the unfortunate habit doctors have developed of dropping out unexpectedly, with a heart attack, I shall keep the faith, hoping to be spared until the history is published. If, however, the Reaper, not Grim Reaper, should elect to touch me on the shoulder with the Flaming Sword before the task is finished, to paraphrase the words of Rev. George White, author of "Statistics of Georgia," "It is enough for me, if, by the tough toil of the literary pioneer, I succeed in breaking and gathering out of the store from the quarry and in hewing the heavy timber from the mountains wherewith hereafter some accomplished architect, in its full proportion and finished beauty, may rear the fair fabric of the Medical History of Georgia."

Report of Committee on Industrial Health, Dr. C. N. Wasden, chairman

See paragraph on Industrial Health of President's report.

Report of Committee on Prepaid Medical Care Plans, Dr. W. S. Dorrough, chairman

The Board after much study and consultation with specialists in the Insurance field has finally reached its initial objective as assigned to it by the Council of the Association and the plan has been launched.

The Board met July 13, 1950 and in consultation with representatives of various Insurance Associations, Councils and Companies, reviewed the "proposed" schedule of fees which was published in the April issue of the *Journal*. There was a discussion of each fee of the schedule, and where possible, changes were made in accordance with suggestions made by members of the Association. The results of this meeting were presented to the Council and the final initial schedule of fees set up was approved by Council. The Council also approved, the participation of the colored doctors of Georgia.

The final schedule with the participating agreement cards were mailed to each member of the Association. Following this the Board received many letters both laudatory and critical. The enlistment of the members as participants in the Plan was slow and the Board met again January 3, 1951 to take up this problem as well as many others concerning technical insurance points and administrative difficulties. The insurance problems were considered and an intensive drive for enlisting participants in the Plan was worked out. We are most grateful to Mr. Schulze of Health Insurance Council of America, Mr. James Andrews, Associate Counsel, Life Insurance Association of America; Mr. Roy Gilbert, Group Manager of Protective Life Insurance Company; Mr. Leslie Tasney, Secretary of Prudential Life Insurance Company and others who attended this meeting and gave us invaluable assistance both from the insurance viewpoint and actuarial experience. The Board was informed that the "old line" companies would participate in the Plan when 65 per cent of the Association's membership had enrolled. As a result of this meeting the Board decided to withhold the selling of any approved policies until the requested 65 per cent of doctors had been enlisted.

The intensive drive for enlistment of participating physicians brought results and the Board met again Jan. 24, 1951 to discuss the approving of policies. In reviewing these policies there was such a wide variation in insuring clauses and exclusions made that the Board, wishing to protect the public as well as its member doctors, began trying to compile a list of regulations and specifications to govern those policies embracing The Georgia Plan. This was a most difficult problem. No experience was to be had from other state plans as none had taken the trouble to issue such protective measures. The Medical Service Department of A.M.A. had no advice other than a copy of a few regulations instituted by Wisconsin. The Board then decided to set up an Executive Committee within itself of five members to facilitate the handling of this and other administrative measures. It is composed of Dr. W. S. Dorrough, Chairman; Dr. John L. Elliott, Savannah, representing Southeast section of state; Dr. Kenneth Grace, LaGrange, Southwest section; Dr. H. L. Cheves, Union Point, Northeast section; Dr. Lloyd Wood, Northwest section; Richard J. Eales, secretary and ex officio member.

The Board then began compiling a list of rules, regulations and specifications for the governing of the policies submitted to it for its approval. Mr. Dunaway, legal advisor of the Association was present at these meetings and it was voted that he pass on the legality of all policies and the legal conformance of these policies to the specifications set up.

The specifications having been compiled and approved by all members of the Board, a meeting was

called March 28, 1951. The same group of Insurance Executives mentioned earlier in report met with the Board and Mr. Dunaway discussed the legal points in connection with approval of the 11 policies submitted. It was found that all of the policies did not meet the specifications in its entirety. Discussion and advice was offered by the Insurance representatives present. The final results of this meeting was the approval of seven policies after minor changes are made in conformance with our specifications. Many other companies have assured the Board that policies will be presented as soon as they can be prepared since the 65 per cent of participation has been passed.

The Board has encountered many difficulties during the year but has adhered to its announced ideal of presenting a Plan built upon sane and sound principles which would protect all parties concerned. It has had much criticism from many members of the Association, while hard to handle and absorb at times, has been appreciated. The interest of the members and their understanding of the Plan is the most essential part of our program and determines its success. It IS the Association's Plan. The Board fully recognizes that the Plan in its initial form is not ideal but it is a sane and sound beginning which can be added to as experience is gained. Every effort will be made to conform to the wishes of the members of the Association where they are in accordance with sane and sound progress.

The Board has made every effort to economically expend the funds allotted to it for the fiscal year. The audit of the Association's finances will show its expenditure in detail.

The Board is most desirous that it be allocated a like sum for the ensuing year. With this allocation it would like a definite clarification as to its authorization to expend these funds.

The Board feels that it is most essential that it have the services of the Association's attorney in passing on the legality of policies. It, therefore, petitions the Council to make provisions for his remuneration for services rendered.

We wish to acknowledge the complete cooperation given by the Public Relations Department in carrying out the immense load of clerical as well as contact work that this undertaking has necessitated. Also, we would like the Council to bear in mind that during the coming year, the work load will not decrease but will grow if the Plan is administered properly.

The Board, while realizing that it has not launched the ideal plan, has made a definite start on a sane and sound basis. It will continue to function, always cognizant of the fact that this is the Association's Plan and with the approval of the Council of the Association. The minutes of the meetings of the Board are always available to the Council.

Report of Committee on Public Relations, Dr. Stephen T. Brown, chairman

Our first action, after the Executive Committee was established on June 11, 1950 was to hire a secretary for the office and we obtained Miss Dene Johnson. Our next move was to engage an executive secretary. This was far from an easy task because there were no trained medical public relations people available at any price.

Thus, we were faced with the necessity of filling the position with a public relations man who had little or no knowledge of the medical profession and its needs. Mr. Richard Eales seemed best fitted for the position and he was hired to start work on August 1. He has a good background of practical public relations experience plus sufficient formal education to fit him for this field. He is interested in the achievement of our objectives both because of personal and

professional reasons, and has worked long and untiringly to get the department organized.

Our first move was to send Mr. Eales to the A.M.A. headquarters in Chicago for a week, and, with this brief training period, he started to work.

The improvement of public relations cannot be accomplished overnight and it is often difficult to find visible results. The department has been occupied with literally thousands of small, seemingly insignificant, routine tasks that, never-the-less, were important and have and will produce good results. These results are, to a great extent, intangible and are difficult to measure, however.

We decided, shortly after the department was established, that the aim of the Association—the improvement of public opinion—could be best achieved by working toward two objectives. These objectives are the foundation blocks upon which any public relations program is built. They are service and information. If the medical profession is to have the respect and trust of the public, it must deliver and obtain the means for delivering the best medical care possible, and secondly, it must inform and educate the public about medical care. The members of the profession must also be informed and educated about their responsibilities to their profession as well as to the public.

In achieving these two objectives, we realized at the offset that adequate machinery was essential. A well organized, well staffed and equipped, smoothly functioning department was necessary, and to this end we have applied at least three-quarters of our time and effort.

It's difficult to realize what this is until you try it. Although the Department of Public Relations was in operation for a short time last year, there was virtually no precedence to guide us. Ordinary office procedure had to be worked out by the trial and error method, and, in all activities, the errors have been numerous and time consuming.

After eight and a half months of operation, we are just beginning to feel that things are shaping up, and next year should see many activities developed, that we wanted to engage in this year.

One of our largest tasks has been assisting in the promotion and administration of The Georgia Plan, the Association's Surgical and Obstetrical plan of insurance. The Plan was, as you know, formulated by the Prepayment Insurance Board, under the able leadership of Dr. W. S. Dorough. The specifications and regulations governing the underwriting of the plan have finally been worked out, some insuring agencies have been approved and are selling the Plan, and the publicity ball has been put into motion, but Dr. Dorough tells me that the work has just begun.

The improvement of press relations is an activity that was started during this last year, and, I think, we can be proud of our accomplishment in this area although much can and must still be done. We recognized, early, the need for the understanding of the press and radio people if our efforts were to be effective. On October 2 we held our First Annual Medical Press and Radio Conference. This conference enabled us to explain that our public relations is a constructive and positive program rather than a negativistic, defensive measure. The news and editorial space devoted to our aims and to the conference was pleasing and far surpassed our expectations. During the conference we proposed that a code of cooperation be worked out to create better relations between the medical profession, hospitals, and the press. It seemed inadvisable to undertake this on a statewide basis, however, and we suggested that each component society initiate such a code to fit its own particular needs. A number of county societies have taken positive steps in this direction, and, just recently, the doctors, hos-

pitals, and members of the press of Fulton County formally established a Code of Cooperation to aid the reporting of medical news.

On February 23, 1951 we started issuing a weekly health news column to all newspapers throughout the state. This column, called "Health Talks" has been well accepted and is a definite service to the newspapers as well as the public.

There are many other methods by which press relations are being improved such as the personal contacts that Mr. Eales makes with editors, reporters, and radio station personnel, but it's sufficient, I think, to say that every effort has and will be made to achieve a better understanding between the press and the medical profession. Every occurrence, of public interest, has been released to the newspapers and radio stations throughout the state and the Department is always available if information is needed by these media.

Personal appearances before audiences are also utilized to disseminate information to the public. Mr. Eales has never failed any group that wished a speaker, and he has spent many hours in the preparation of talks for P.T.A. assemblies, Kiwanis Clubs, Rotary Clubs and others. In all he has appeared before 45 audiences in the short time with us. Also, he has written a number of speeches for other people and the department is continually called upon to furnish material about medical care and the Government Health Plan.

The Department has made the transcribed radio programs, prepared by the A.M.A., available to radio stations throughout the state. These programs are an excellent informational medium and a greater distribution of them is planned for the next year.

We regarded the need for increased interest and activity on the part of the members of the Association as very important, and have made that a goal to work for continually. Mr. Eales and I, both, have tried to visit with every district society and Dick has met with many county societies since taking over as Executive Secretary.

We have published five editions of our monthly news letter and it has been well received. This is the best way to inform the members of the Association about the activities of the department and Public Relations news in general.

Good equipment is essential to efficient operation as all of you know and we have recently found it necessary to add some new equipment for use in the office.

One, a Multigraph Duplicator, which is actually a small off-set printing press, will enable us, not only to do more and better work, but to reduce operating costs considerably. With this machine, many pieces of literature—pamphlets, small booklets, and our monthly news letter, can be printed in the office at from 33 to 55 per cent less than a commercial printer would charge. For example, this booklet on The Georgia Plan, that was sent to every member of the Association, was published in our office at more than a 46 per cent saving.

Much public ill-will has resulted from the people's inability to question the medical profession's actions. The establishment of grievance committees on the state and county level has been found to be an effective way to alleviate this sore-spot, and we have worked for such society action. The Council for The Medical Association of Georgia was given this function and, at our instigation, many of the component societies have appointed such committees.

A number of the societies have responded to our call and have taken action on the complaint that a doctor cannot be obtained in an emergency. Around-the-clock emergency service is now being offered

through the Fulton County Medical Society's Doctors Registry.

Much effort has been expended to educate the medical profession itself, and, with this statement, I'll proceed into the third and final part of this report.

Gentlemen, the Public Relations Committee is aware of the need for continued effort along the lines that we've been following. It's aware, also, of the need for many more activities, but there's one thing that the committee feels is necessary above all else. That is—a realization, on the part of every physician, of his responsibility to public opinion.

The Department of Public Relations cannot be dispensed with but as long as public ill-will is being earned by many doctors through their unthinking and irresponsible actions and as long as we fail to make every effort to improve medical care in our own communities, the mistrust and antagonism of the public will continue.

It seems that appeals to the individual physicians, who are guilty of practices that earn the ill-will of the public, have and will continue to fall on deaf ears. If they were interested in the good will of the public for themselves and the profession the appeals would not be necessary.

It is the consensus of the Public Relations Committee, therefore, that group action is necessary. Much of the action, however, does not fall within the scope of the state association, but must be initiated and carried out by the county medical societies. Each society must ferret out the reasons for poor public relations in its community and take the necessary remedial steps and must also do all in its power to better medical care.

The Department of Public Relations of The Medical Association of Georgia has, as one of its major objectives, the promotion of county society activity during this next year. The department can and will help the component societies in every way possible.

Also the department must, of course, promote statewide activities—that is its major function.

We hope to get a Code of Cooperation between the medical profession and the news people adopted on a statewide basis soon. In connection with that, we are establishing, in cooperation with the Georgia Press Association, a Medical Association of Georgia Press award for the daily and weekly newspaper that best promotes health and medical care matters in its community. This award will be announced at the next annual press association convention to be held in July and the first awards will be presented at the 1952 convention.

We hope to obtain the distribution of the film, "To Your Health," in theaters throughout the state. This was started during this past year but we have not, as yet, received the backing of all the component societies. The issuance of medical information to schools throughout the state; the organization of speakers bureaus in every community; the distribution of literature; a more effective utilization of the Woman's Auxiliary; and, in short, everything that will further medical care and obtain the respect and understanding of the public will be our goal.

Now, gentlemen, the achievement of better public relations is an important function of the medical association, but it requires a lot of work, sufficient personnel, and a lot of money.

In the eight and a half months that the department has been in existence, we spent only \$11,672.66 of the \$15,000 that was allotted to us by the Council. A budget report is attached to the copy of this report for your perusal. You may think that, having operated on 77 per cent of the budget set aside, we can get by on that much next year, but bear in mind that during

the first four months of the year, the department did not exist. Further, the organization of the department and the training of the personnel required time that would have otherwise been spent in normal activities.

To attain the objectives of the of the association in the coming year, a considerably larger budget will be needed. The staff must be enlarged to take some of the routine duties off of Mr. Eales' hands and render more help and service to the component societies. The Administration of The Georgia Plan will become an increasingly greater task. More materials and equipment will be needed; funds should be available to purchase films and radio programs for schools, radio stations, and other users; and the newspaper space will have to be bought.

Based on the experience of the past eight months, we will require, at least \$25,000.00, and that is, by no means, an exaggerated estimate.

That is a lot of money, but when you consider the fact that labor organizations and other trade associations expend twice, three times, and ten times that sum to further aims, some of them antagonistic to the medical profession, \$25,000.00 seems like a small amount to enable us to practice medicine unfettered—without the shackles of bureaucratic controls.

Remarks: Past President B. H. Minchew, Waycross

During the afternoon probably not more than 60 per cent of the reports of committees were made. Probably not more than 60 per cent of the chairmen of committees were here to make reports.

I am sure you realize, as does this body, that the work of the committees is a very important part of the structure of the House, and if some other means could be devised by which we could have the chairmen send in their reports, or they could be gotten here to give them, either following Dr. Richardson's suggestion of appointing a Speaker of the House or some other officer whose duty it would be to see that such reports were ready to be given, it might solve our problems.

(To be continued)

OBITUARY

Dr. Caroline Kreiss Pratt, aged 38, Atlanta, U. S. Public Health Service official and medical officer of the Communicable Disease Center, Chamblee, drowned at Fernandina, Fla., while attempting to rescue her 6-year-old son from the surf, May 22, 1951. A native of California, Dr. Pratt graduated from Washington University School of Medicine, St. Louis, Mo., in 1942. She was a surgeon and came with the Communicable Disease Center, Atlanta, in 1946. She resigned in 1947 to become medical director of the Atlanta Red Cross Blood Center but returned to the Communicable Disease Center two years later as medical officer. She held the rank of lieutenant commander with the Public Health Service.

Dr. Pratt was a member of the faculty of the Emory University School of Medicine, a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, and the American Woman's Medical Society. She belonged to the Episcopal Church. Surviving are her husband, Harry D. Pratt; three children, Harry, Jr., Katherine and George Pratt; her parents, Mr. and Mrs. George A. Kreiss, San Mateo, Calif., two sisters and one brother. Funeral services and burial were held in Cypress Lawn Cemetery, Colma, Calif.

SPECIAL NOTICE

Association of Paralytic Poliomyelitis with Recent Immunization

T. F. SELLERS, M.D.

Director, Georgia Department of Public Health
Atlanta

Studies made during epidemics of poliomyelitis in Australia and England in 1949 showed an increased incidence of paralysis in this injected extremity when an immunizing agent had been administered less than 30 days prior to the onset of polio. Subsequent and, as yet, unpublished studies conducted in New York and Minnesota confirm these findings.

These results indicate that if an immunizing agent is administered to a child at about the time he becomes infected with the polio virus it may precipitate paralysis in the injected extremity. Apparently, the effect of immunization is limited to the extremity into which the agent is injected and does not make the child more susceptible to polio.

Under ordinary circumstances the possibility of precipitating paralysis in this manner is extremely remote and may be ignored. On the other hand, during an outbreak of polio in a given locality, it may be well to postpone immunization until the abnormal prevalence of the disease has subsided. For the present, however, and until such time as the disease may reach epidemic proportions, it is desirable that immunization be continued without interruption.

NEW APPOINTMENTS AND PROMOTIONS ANNOUNCED AT EMORY UNIVERSITY

Dr. Curtis Dudley Benton, Jr., of the E.E.N.T Service at Atlanta's Grady Memorial Hospital, has been appointed associate in ophthalmology in the Emory University School of Medicine, and research director of the Grady Clay Memorial Eye Clinic, according to announcement of appointments and promotions released recently by Dr. Goodrich C. White, Emory president.

Dr. William Cecil McGarity of Emory hospital, and Dr. Roy Lamar Robertson of Grady, have been appointed instructors in surgery. Dr. James Anthony and Dr. James Lowell of Emory have been named research fellows in surgery.

On a voluntary basis Dr. Rolla Eugene Dyer, director of research for the Emory Winship clinic, will serve as professor of medicine. Others joining the medical faculty on a voluntary basis are: Dr. Augusta Elizabeth Willis, Dr. John Dudley King, Dr. Thomas Murrell Thornhill, Jr., Dr. John Gordon Brackett, Dr. Franklin Heywood Goodwin, Dr. Alvin David Josephs, Dr. Wyman Platt Sloan, and Dr. John E. Taylor.

New instructors in the Emory Nursing School are Mrs. Seraphima A. Boguslavsky and Miss Margaret Spears.

Dr. J. D. Martin, Jr., of the medical school has been promoted from associate professor of surgery to professor of clinical surgery; Dr. John B. Cross from assistant professor of clinical obstetrics; and Dr. Vernon E. Powell from instructor to assistant professor of clinical medicine. Three have moved from rank of instructor to associates in otology, Dr. William C. Hathcock, Dr. James T. King, and Dr. Buford L. O'Neal.

The following medical school teachers have been promoted from assistant to instructor: Dr. Stephen Barnett, Dr. Charles E. Brown, Dr. C. Daniel Burge, Dr. John S. Fish, Dr. David R. Ginder, Dr. J. Frank Harris, Dr. Joseph H. Hilsman, Dr. George A. Niles, Dr. Samuel R. Poliakoff, Dr. W. Vernon Skiles, and Dr. Charles W. Smith.

NEW BOOKS

Books for review should be sent to the Book Review Department, Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Ga. Acknowledgement of receipt will be made in these columns, and those selected for review will be based on merit and interest to our readers.

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY: By W. A. Newman Dorland, A.M., M.D., F.A.C.S., Lieut.-Colonel, M.R.C., U. S. Army; Former Member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association. New 22nd Edition. 1736 pages, with 720 illustrations, including 48 plates. Philadelphia and London: W. B. Saunders Company, 1951. Price \$10.00.

A Complete Dictionary of the Terms Used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Nursing, Veterinary Science, Biology and Medical Biography with their Pronunciation, Derivation and Definition.

PRINCIPLES AND PRACTICE OF OBSTETRICS: By J. P. Greenhill, M.D., Attending Obstetrician and Gynecologist, The Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, The Chicago Lying-In Hospital; Attending Gynecologist, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. New, 10th Edition. 1020 pages, with 1140 illustrations on 864 figures, 194 in color. Originally by Joseph B. DeLee, M.D. Philadelphia and London: W. B. Saunders Company, 1951. Price \$12.00.

In the past the DeLee-Greenhill textbooks of obstetrics have been noted for their completeness, thoroughness, and readability. Nothing was left out. The medical student, teacher and general practitioner could always find help on any problem presenting itself. In the new 10th edition, just off the press, this reputation has been well maintained. There are about the same number of pages and illustrations as in the 9th edition. However, there has been much deleting and addition of new material in the text as well as in the illustrations. The author has modernized and brought all subject matter up to date. He has shown wisdom in freely calling in specialists in the several fields, not only to assist and collaborate with him, but in many instances to write entire chapters. This in no way detracts but rather adds character to the work.

The book although modernized follows in general the same pattern and tone of the first edition. As will be remembered, the first edition was written 38 years ago by DeLee, and to use his words "by the bedside, in the ghetto district by lamp-light, amid the odors of garlic and onions." Perhaps this best illustrates the pioneering spirit he had, and explains the unusual style, clarity and attractiveness of his writings. It is to be hoped that none of these qualities will be lost in future revisions of the book.

It is extremely noteworthy that before revision was begun on this book there was a conference between four leading American authors of textbooks on obstetrics. Those participating were Greenhill, Eastman, Titus and McCormick. This was done in order that uniformity might be obtained in the matter of teaching obstetrics. There was agreement on several somewhat controversial matters, such as classification of toxemia of pregnancy, breech presentation, types of placenta previa, engagement, station and definitions of low, mid, and high forceps. In addition agreement was reached "that external caliper measurements of the pelvic inlet are of no value and should be abandoned." This progressive step will have far-reaching consequences and will undoubtedly be appreciated by students, teachers as well as the practi-

tioner. It should result not only in greater uniformity of the knowledge of the subject matter but also conducive to clearer thinking. It would seem that other authors might well emulate this plan.

No one thing so well attests the esteem and high regard for this book than the fact that it has been adopted by so large a number of medical schools for so long a time.

C. B. UPSHAW, M.D.

PARACELSUS. Magic Into Science. Henry M. Pachter. Published by Henry Schuman, New York, 1951. 360 pages. \$4.00.

This account of the fascinating, versatile medical and scientific genius of the 15th century, written by Henry M. Pachter, is announced as "being the true history of the troubled life, adventures, doctrines, miraculous cures, and prophecies of the most renowned, widely traveled, very learned and pious gentleman, scholar, and most highly experienced and illustrious physicus, the Honorable

Philippus Theophrastus Aureolus Bombastus ab Hohenheim, Eremita, called PARACELSUS, doctor of both medicines and professor of theology, also adept of the Holy Cabala and expert of the alchemical art, friend of the common man and defender of liberty.

He cured patients whom ordinary doctors had abandoned for doomer, and he knew wonderful elixirs that restore youth to the old." In spite of his overwhelming family name, he preferred to be called Paracelsus because he said he was superior to the Roman physician, Celsus.

For complete understanding of the course of medicine through the centuries, one cannot overlook the part played by this remarkable man as a factor in the early establishment of medicine on a scientific basis. Nor can one conceive of the idea better than through the pages of this new book, a volume to delight the earnest student of history.

We may smile at his amazing eccentricities, but must admit with many authorities that Paracelsus, during his forty-eight exciting years of life, rendered such service to humanity as to entitle him to be classed with the greatest physicians of all time.

The author asks, "Was Paracelsus a medieval magus or a modern scientist? A charlatan or a gifted healer? An imposter who grafted half-baked speculation on to careless and ill-conceived experiments, or a deep thinker whose genius grappled with problems beyond the grasp of his time? He has been praised beyond his merits by some, and underestimated by others."

The object of the book is to endeavor to answer these questions, and to understand the man, Paracelsus, "with all his conflicts." Not only has the author succeeded well in his objectives, but also he has drawn a vivid picture of this period of the Renaissance, with its glamorous times and people.

FRANK K. BOLAND, M.D.

NEXT ANNUAL SESSION
of the
MEDICAL ASSOCIATION OF GEORGIA
ATLANTA BILTMORE HOTEL
ATLANTA
Dates: May 11, 12, 13, 14, 1952

THE WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

TWENTY-SIXTH ANNUAL REPORT

APRIL 17, 1951

As president of the Woman's Auxiliary to the Medical Association of Georgia, it is my honored privilege to submit the following report of work accomplished by our Auxiliary this past year.

The Auxiliary Executive Board met April 20, 1950, in Macon, following the annual convention. Delegates to the American Medical Association Convention were appointed and plans for the year were discussed.

On August 25, 1950, the Executive Board of the Auxiliary met with the members of the Advisory Committee from the Medical Association of Georgia, in Atlanta, at the Academy of Medicine and presented our plans for the year's work to them. Dr. A. M. Phillips, president of the Medical Association of Georgia appointed the following members to serve on the Advisory Board this year: Dr. Murdock Equen, Dr. Lehman Williams, Dr. J. R. S. Mays, Dr. J. Harry Rogers, Dr. Eustace A. Allen, Dr. W. Bruce Schaefer, Dr. Ralph H. Chaney, Dr. W. G. Elliott and Dr. W. L. Bazemore. After our plans were discussed, Dr. Equen announced that the Advisory Committee approved the Auxiliary plans for the year, and that the board also approved, Mrs. Ben Hill Clifton's recommendation for the quarterly mailing of a four-sheet news bulletin, and gave their permission for her to present plans to Council for approval. Our State President, Dr. Phillips, approved this publication and felt that we were entitled to a news bulletin, but stated, that no provisions were made or funds available for such a project this year, sorry, we did not get our news bulletin started this year, but have hopes that our dream of a news bulletin will soon be a reality.

We are grateful to the members of the advisory committee for their interest in our objectives and for their assistance and support during the year. We adopted, "Plan, Cooperate, Progress" as our theme for the year.

On August 26, the Auxiliary held its fourth annual mid-summer conference, at which county presidents and presidents-elect met with the Executive Board for a fuller discussion of suggested work. Mr. Richard Eales, Executive Secretary of Public Relations for the Medical Association of Georgia, gave an excellent talk on the great need for Good Public Relations. He spoke of the value of a doctor's wife to the profession, in their Public Relations.

Dr. Murdock Equen, Chairman of the Advisory Committee and Dr. Lehman W. Williams, a member of the Committee, spoke briefly at the luncheon which followed this meeting.

Mrs. J. R. S. Mays, the President-elect and Organization Chairman, reports the largest membership the Auxiliary has ever had, 1,115. We are happy to have gained more members to serve the Medical Association of Georgia. There are 32 local Auxiliaries and nine of the Districts are organized and active. With local Auxiliaries and members at large we are represented in 72 counties of our State. One new Auxiliary was organized this year, Hall County, with a grand start of 20 paid members.

The Auxiliary has had many and varied programs during the year, which is one of our important objectives. I would like to mention the names of the speakers and elaborate on the subjects, but the Chairmen will do that when they give their reports to the Auxiliary. However, it will be interesting for you to know the topics of the subjects given. They are as follows: "Personal Observation of Health Conditions in Europe"; "The Story of Anesthesia"; "Music Therapy"; "Atomic Defense"; "The Child Guidance Center"; "Notions on Neurotics"; "Life's Deeper

Dimensions"; "A Doctor's Philosophy"; "It's Your Crusade, Too"; a playlet,—forum on "The Doctor, Minister. Patient Relationship"; "The Crimson Tide"; "Medical Aspects of Civilian Defense"; "Tuberculosis, the Community Problem"; "The White Witch"; "Movie on Cancer in Women"; "Medical Ethics for the Doctor's Wife"; "Normal People Have Problems"; "Medicine in Europe"; "Hands Off Those Gay Autumn Leaves"; "Conservation of Hearing in School Children"; "Feet and Shoes"; "Cosmetics, Bleeders and World Government"; and "Medicine in South America".

Mrs. Harry Bridges, Past Public Relations Chairman, gave a talk on Georgia Legislature and how it affects our Doctors.

Mr. Richard Eales, present Public Relations Director of the Medical Association of Georgia, gave a very interesting and informative talk on Public Relations.

And, my subject was "Our Auxiliary" at all the meetings I had the pleasure to attend.

Dr. A. M. Phillips was the guest speaker on the program for the Sixth District Auxiliary meeting.

A number of Radio Health talks were given during the year—44. Thirty-six health films were shown and six films scheduled to be shown April 23 and 30.

Community health and welfare projects the auxiliaries have participated in: P.T.A. Health Round-Up—Service League Activities. Members of one Auxiliary served as Chairman of Free Speech School and worked on case histories for same, served as Regional Chairman of the Northwest Georgia Health Conference, and helped organize and direct free maternity and child welfare clinics. Members served as Medical Chairmen for the Open Door Home, which is a home for dependent children. Another Auxiliary gave pajamas to needy patients and gave waste baskets, one for each bed in a T. B. Hospital. Distributed 530 candles during Cancer Light Up Campaign. Served as hostess at the opening of St. Francis Hospital in Columbus, Georgia.

Members assisted the prenatal clinic of the Bibb County Public Health Department, giving 762 hours to this work and sponsored 47 demonstrations on nutrition at the clinic. Colquitt Auxiliary tested 500 children in an eye and ear survey in the county schools.

Richmond County Auxiliary, adopted for their 1950-1951 local project the establishment of a loan closet of sick room needs for the indigent sick at home. The committee met with Dr. Abe Davis, Health Commissioner, to determine the greatest needs. They decided to concentrate on the essential needs for new born infants and the mothers. The Committee made gowns, diapers, dressings and cotton pledgets and other needs. They keep the clothes mended and replace old for new when needed. The bundles are kept with the Department of Health and distributed by the Public Health nurses. The nurses notify the Auxiliary when they deliver the bundles, which are loaned for ten days. Two hospital beds and a pair of crutches are available for loan also.

With the cooperation of the Waycross Service League, Ware County Auxiliary started a Tonsilectomy Clinic, where the doctors give their service and the Auxiliary and Service League pay the hospital expense. Since last September, 42 tonsilectomies have been done. This Auxiliary staffed an office at the Public Health Office, for a week while a Diabetic Survey was taken. Approximately 12,500 specimens were examined and filed.

We are proud of the recognition and the remarks given Fulton County Auxiliary in the Public Relations

Bulletin of the A.M.A., they complimented this auxiliary for joining with the Medical Society in a mass blood donation for the Red Cross, saying this, as far as was known, was the first mass donation of blood by a Medical group, as such. Fulton also manned the hemoglobin booth for the Chamber of Commerce Health Week in October, at which time 600 were given this test.

Over 30 Health Education programs were held during the year, that were open to the public, with an approximate attendance of 12,951.

Our members are leaders in their Community Health activities and it is through them that the public has become health conscious.

Approximately 20,000 pieces of Health Literature have been distributed.

Mrs. J. Harry Rogers, our immediate past State President, reports on Public Relations as follows: A number of Auxiliaries furnished speakers to lay groups on compulsory health insurance and on health subjects.

In June all county Presidents and their members were urged to write our Senators and Representatives and ask them to oppose President Truman's Reorganization Plan No. 27. Many did and we feel that our efforts had something to do with defeating the bill. We are particularly proud of Floyd County Auxiliary, which set up a telephone committee to call all members to write their Congressman, who had not previously gone on record with us. This time he did, so we feel that Floyd Auxiliary helped him make up his mind.

Fulton County sponsored a civil defense meeting, open to the public. The first meeting of its kind held in Atlanta. This Auxiliary entertained wives of the members of the Georgia legislature at a luncheon.

Bibb County sponsored a meeting at which Mrs. Bruce Schaefer, a past State President and former legislation chairman of the National Auxiliary, spoke before Presidents of the Women's Civic Clubs of Macon. In cooperation with the Bibb County Medical Society they presented Dr. Hilton Read, of Atlantic City, New Jersey, his address, "Notions on Neurotics", was heard by about 600 people.

DeKalb County sponsored a radio program on cancer for twelve weeks, with their members taking part and also sponsoring a movie on cancer.

Floyd County manned the blood bank at the County Fair and also sponsored an essay contest on "Romance and History of Medicine in Floyd County" among high school children.

The Georgia Medical Society Auxiliary, (Chatham County), gave a card party for the benefit of the Cerebral Palsy School and set up a clothing bank for the Cerebral Palsy children of that section. They sponsored a serviceman's coffee hour at the S.S.S.S. and have invited wives of service doctors to their meetings. The Auxiliary assisted the Medical Society at a booth at the Coastal Empire Fair, with about 1,000 people visiting the booth each day. Governor Talmadge was given a pamphlet "The Voluntary Way Is the American Way," as he stopped to visit our booth.

Cobb County Auxiliary sponsored a campaign to clean up vacant lots and eyesores in Waycross.

Richmond County furnished pamphlets on compulsory health insurance to high school students for debate and presented Grant Husband, in an address on "Normal People Have Problems," at a large public meeting.

Glynn County Auxiliary placed 16 lamps in private rooms in a hospital and made favors for hospital trays during holidays.

Members from various Auxiliaries, served at Chairman of Health Legislation and Public Relations in other organizations. One member was State Health Chairman of the P.T.A. Members worked with milk

fund drives, tuberculosis, polio, heart, cancer, cerebral palsy, dental and many other health drives. They also assisted the Red Cross, Community Chest and with the Crusade for Freedom. Members have held office in the League of Women Voters, the Y. W. C. A., The American Association of University Women, the Child Guidance Centers, The Federation of Women's Clubs on State, District and local levels, various religious groups, with Community Planning Councils, with Safety Councils. Four of our members served on the Governor's Committee for the White House Conference on Children and Youth.

Our seventh objective, all members were urged to plan study groups and be informed on all legislation of interest to the Medical profession. Mrs. Harold Smith served as chairman during the year. The Woman's Auxiliary has made great progress in legislative work. We are reminded, however, that socialized medicine is far from dead. We must continue reading and studying to keep intelligently informed on this subject. Do not forget our boys are fighting in Korea, and we must continue our efforts on the home front to see that their rights, as individuals, are preserved for their return. "The Doctor Draft," the A.S.T.P., and the V-12 program have been the most important bills during the year. The doctors being well informed, needed no assistance from us.

The tenth objective, stressing subscriptions to "Today's Health", the National Health Magazine, published by the A.M.A. and the Bulletin, official publication of the Woman's Auxiliary to the A.M.A., shows a result of 270 "Today's Health" subscriptions and 77 Bulletin subscriptions.

The Auxiliaries have been very cooperative in reporting their activities to Mrs. Ben Hill Clifton, our Editorial Chairman, for publication in The Journal of the Medical Association of Georgia. At this time, I would like to express our many thanks to Dr. Edgar Shanks and Miss Viola Berry, for their interest in giving the Auxiliary space and publishing our news items in the State Journal. Until our news bulletin is printed, may I urge each doctor to take his Medical Journal home each month so that his wife can keep abreast of what is going on in our State Auxiliaries.

This year, 10 papers were reported on Research in Romance of Medicine. I feel sure there are more but to date, this is the report. These papers will be placed in the permanent file cases in the Academy of Medicine in Atlanta.

Contributions from members to the Student Loan Fund this year, amounts to \$221.00. The balance in the fund is around \$5,000.00, which is available for loans to eligible medical students. One of the Auxiliary's special projects is the Camellia Garden at the State Hospital in Milledgeville.

Last April the Baldwin Medical Auxiliary was appointed custodian of the State Camellia Garden. This year the garden has been worked by a group of patients (men) under the supervision of an attendant, fertilized, mulched and watered when necessary. The ladies of the Auxiliary rotate each three months in supervising the care of the garden. The Auxiliary has planted dogwood, spirea, crepe myrtle and are planning to plant bulbs in the fall. There are over 100 Camellia plants and about 500 Azalea bushes in the garden. I had the pleasure of visiting the garden during the year and some day it will be one of Georgia's gardens we will all be proud of.

The garden was started three years ago by contributions from the county auxiliaries. This year nine auxiliaries contributed.

During the year approximately 160 auxiliary meetings were held and good attendance reported from the county presidents.

Each year the auxiliary awards a prize to the county auxiliary whose achievements for the year were the

most outstanding, and to the county auxiliary displaying the best publicity in their scrapbook and having the best exhibit at the convention and the auxiliary reporting the greatest number of requirements for the year's work, receives the Mrs. James N. Brawner Trophy. I am sure the committees will have a hard time deciding on who gets the awards, for all the auxiliaries have done marvelous jobs this year. I am truly proud of my "girls".

Our first objective, and one that is stressed each year, is to invite every eligible doctor's wife in your community to be an interested and active member of the Woman's Auxiliary to the Medical Association of Georgia. This is of utmost importance, for our third objective is to secure confidence among our doctors and their families, promoting good fellowship and cooperation. All the auxiliaries have social hours in connection with their meetings and in this way we become better acquainted with each other. This year every auxiliary celebrated "Doctors' Day", some affairs were formal and some most informal, with hill-billy music and square dances at Country Clubs, red carnations were sent to Doctors' offices and to our doctors who were ill, many original skits were given, but the most unique one was "A Womanless Fashion Show". The lovely models were all members of the Georgia Medical Society. They modeled fashions of "Then and Now". The newspapers and radio stations were most generous with their editorials and comments on "Our Doctors."

Permit me, please, to say a few words about my activities as State President, during the past twelve months. I have represented the auxiliary on many occasions. I attended the Thirty-Sixth Annual Convention of The Georgia Congress of Parent and Teachers in Savannah, April 26-27-28, 1950. The Second Georgia Conference on Family Life, in Atlanta, May 5, 1950. I attended the open house at the Cerebral Palsy School. I am a member of the Public Service Council of the Savannah Federation of Women's Clubs and have attended several of their meetings during the year. I attended the Public Relations meeting of the Bibb County Medical Society and Auxiliary in Macon, February 13, 1951. The speaker was Dr. Hilton Read of Atlantic City, N. J., his subject "Notions on Neurotics".

I served on the nominating committee for the Woman's Auxiliary to the Southern Medical Association, in St. Louis, Missouri, November 1950. I served on the Chatham County Auxiliary card party committee; served on the street sale for the Polio Drive; assisted the Shriners at their Easter party for the Orphans and Crippled Children; assisted several other organizations on drives.

I served as Chairman of the Women's Committee for the Lions Club, during their broom sale for the benefit of their eye glass clinic. I also served as President of the Woman's Auxiliary to Alcee Temple. The work in this auxiliary is to assist the Shriners with the children at the Crippled Children's Home in Greenville, S. C., and to do follow-up work.

I have spoken to six district meetings and I have attended meetings of the following county auxiliaries, several more than once: Bibb, Chatham (Georgia Medical Society), Cobb, Colquitt, DeKalb, Dougherty, Fulton, Glynn, Muscogee, Richmond, Lowndes (South Georgia) and Tift. I am sorry that I could not accept several other invitations from auxiliaries. I have attended six Executive Board meetings.

I have traveled 9,554 auxiliary miles this year. This includes my trip to St. Louis meeting. I have written hundreds of letters and sent cards to the sick, to the bereaved, and cards of congratulations to Dr. Frank Pickett, Ty Ty, Georgia, for his fifty-three years of medical service in his community; and to Dr. Elmer Henderson for his new honor, being elected to president of the American Medical Education Foundation.

I compiled the plans for 1950-1951 and The Highlights 1949-1950, for our year book Woman's Auxiliary to the Medical Association of Georgia, with the assistance of my corresponding secretary, Mrs. C. R. A. Redmond. I addressed and mailed about 1,200 of these books.

At this time I want to introduce my officers and the honored guest, who will address our auxiliary during the convention, Mrs. Mason Lawson, third vice President of the Woman's Auxiliary to the American Medical Association and Mrs. L. S. Thompson, president of the Woman's Auxiliary to the Southern Medical Association. My officers are President-Elect, Chairman of Organization, Mrs. J. R. S. Mays; first vice-president and chairman of Program, Mrs. Ralph Fowler; second vice-president and chairman "Today's Health", Mrs. John W. Turner; third vice-president and Scrapbook Chairman, Mrs. Paul T. Russell; recording secretary, Mrs. Leo Smith; corresponding secretary, Mrs. C. R. A. Redmond; treasurer, Mrs. Lucius N. Todd; historian, Mrs. Robert Crichton; parliamentarian, Mrs. W. Bruce Schaefer. The chairman of Standing Committees: Achievement Award, Mrs. William H. Benson; Archives, Mrs. C. W. Roberts; Budget, Mrs. Ralph H. Chaney; Bulletin, Mrs. Milford B. Hatcher; Doctors' Day, Mrs. Virgil Williams; Editorial, Mrs. Ben Hill Clifton; Mrs. J. Bonar White Exhibit and Scrapbook Awards, Mrs. Dan Jardine; Legislation, Mrs. Harold Smith, Public Relations, Mrs. J. Harry Rogers; Research in Romance of Medicine, Mrs. T. J. Ferrell; Revisions, Mrs. Lee Howard; Student Loan Fund, Mrs. Shelley C. Davis; Trophy, Mrs. James N. Brawner, Sr.; Special Committee Camellia Garden, Mrs. R. W. Bradford.

This has been a year of interesting experiences for me and a profitable year. I say profitable because I have gained so many friends in all parts of our beautiful Georgia and shall treasure the memories of their true Southern hospitality as long as I live. I have visited many sections of our beautiful State and now know Georgia better than I have ever known it.

In behalf of the members I extend heartfelt thanks to the Medical Association of Georgia, for their support in all of our activities and if your wife is not a member of the Auxiliary will you encourage her to join this year.

To all of my officers and chairman and to all the county presidents and district managers, who have cooperated with me in all of our endeavors, during the year, I extend my love and heartfelt thanks, and to my loyal, patient husband, who has been the "forgotten man", bless his heart, I promise my devotion. Thanks Lehman for being part of the auxiliary from April 1950-April 1951.

In closing, may I remind you to always "Plan, Cooperate and Progress."

Respectfully submitted,

MRS. LEHMAN W. WILLIAMS, President
Woman's Auxiliary to the Medical
Association of Georgia. 1950-1951.

ANNOUNCING A NEW DEPARTMENT

"Letters To The Editor"

Send in your comments. Also questions concerning medical topics and organization.

NEWS NOTES AND COMMENTS

CALENDAR OF MEETINGS

FIRST DISTRICT MEDICAL SOCIETY, Savannah, June 22. Dr. Wm. H. Fulmer, 19 East 34th Street, Savannah, Secretary.

THIRD DISTRICT MEDICAL SOCIETY, Americus, June 21. Dr. Schley Gatewood, Americus, Secretary.

SIXTH DISTRICT MEDICAL SOCIETY, Dublin, June 28. Dr. Charles H. Richardson, Jr., 700 Spring St., Macon, Secretary.

GEORGIA CHAPTER American College of Surgeons, Bon Air Hotel, Augusta, October 18. Dr. James H. Semans, 34 7th Street, N. E., Atlanta, Acting Secretary.

GEORGIA UROLOGICAL ASSOCIATION, Bon Air Hotel, Augusta, October 18. Dr. Reese C. Coleman, Jr., 490 Peachtree, Atlanta, Secretary.

GEORGIA ORTHOPEDIC SOCIETY, Bon Air Hotel, Augusta, October 18. Dr. John I. Hall, 666 Cherry Street, Macon, Secretary.

GEORGIA STATE SOCIETY OF ANESTHESIOLOGISTS, Bon Air Hotel, Augusta, October 18. Dr. Perry Volpitto, University Hospital, Augusta, Secretary.

GEORGIA DIVISION, AMERICAN CANCER SOCIETY, Bon Air Hotel, Augusta, October 18. Dr. J. Elliott Scarborough, Emory University Hospital, Emory University, Chairman.

GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY, Augusta, October 18. Dr. Jule C. Neal, Jr., 203 Professional Building, Macon, Secretary.

GEORGIA RADIOLOGICAL SOCIETY, Bon Air Hotel, Augusta, October 18. Dr. Robert Pendergrass, Americus, Secretary.

GEORGIA HEART ASSOCIATION, Hotel General Oglethorpe, Savannah, September 14-15. Mr. Linwood Beck, 11 Pryor Street Bldg., Atlanta, Secretary.

At the monthly meeting of the **Dougherty County Medical Society** held at the Phoebe Putney Memorial Hospital, Albany on May 31, Dr. Charles E. Dowman, of Atlanta, discussed "Head Injuries."

The following members of our Association were scheduled to attend the **A.M.A. Meeting in Atlantic City**: President W. F. Reavis; Delegates Eustace A. Allen, B. H. Minchew and C. H. Richardson; Secretary-Treasurer David Henry Poer; Bruce Logue; Carter Smith; Richard Torpin; Daniel C. Elkin; Carl C. Aven; Robert C. Pendergrass; Thomas L. Ross, Jr.; James E. Paullin; Allen H. Bunce; Walter L. Bloom; E. M. West; Murdock Euen; W. H. Grimes; R. A. Bartholomew; E. D. Colvin; John S. Fish; Wm. M. Lester; Robert L. Bennett; H. E. Nieburgs; E. R. Pund; F. W. Cooper, Jr.; Bernard S. Lipman; J. Drennan Lowell, and Harold P. McDonald.

In the next issue of **The Journal** the Delegates will report on the activities of the Association to the members in Georgia.

The annual meeting of the **State Board of Health** was held in Atlanta on May 24 and the following items of business were transacted: I. The following legislation that was enacted by the General Assembly of 1951 was announced: (a) The Transfer of Crippled Children's Program from the Welfare to the State Department of Public Health, effective July 1, 1951. (b) By an act of the General Assembly the State Board of Health was empowered to build and operate a general hospital at Augusta. (c) A Commission on Alcoholism was established. (d) An appropriation of \$100,000 enabled Battey State Hospital to contract with local hospitals for the care of tuberculous patients on a patient per diem basis. (e) An increase in appropriation to the Georgia Department of Public Health from \$2,100,000 to \$3,000,000 was announced. II. The Board adopted a Tourist Court and Trailer Park Regulation requiring an operating permit, obtainable only after certain public health standards have been met. The new regulation is a revision of an older one, with new sections added on heating, fire protection, communicable disease, and a penalty clause making violation a misdemeanor. III. A regulation forbidding the "importation, purchase, breeding, giving away or offer of sale of birds of the psittacine family" was amended by the Board of Health. Sale or shipment of such birds as parrots, parakeets, love birds will be permitted if accompanied by a permit from the State Health Department. IV. Regulation was passed calling for the issuing of certificates and permits for "gathering, handling, storing, shucking, packing, shipping or selling" of shellfish. V. The Director advised all children to have immunization against diphtheria and whooping cough, since it will not make them more susceptible to polio.

Everyone welcomes the confirmation of **Major General George E. Armstrong** as Surgeon General of the Army for a four year term beginning June 1, 1951.

The Gold Heart Awards of the **American Heart Association** for 1951 went to Dr. James B. Herick, Chicago; Dr. Frank N. Wilson, Ann Arbor, and Dr. H. M. Marvin, New Haven. These medals were presented at the Annual Dinner of the Association in Atlantic City on June 9.

The Annual Session of the Georgia Chapter, American College of Surgeons will be held in Augusta, October 18, 1951, under the direction of Dr. Peter B. Wright, President. Dr. Alton Ochsner, New Orleans, President-elect of the American College of Surgeons, and Dr. Paul R. Hawley, Chicago, Director, have accepted invitations to appear on the program.

A Tele-Clinic, 16 mm. sound film, spotlighting conferences and sessions of the recent meeting of the American Academy of General Practice is available for your use. Address Wyeth, Inc., Philadelphia, or the Medical Association of Georgia office, 875 West Peachtree Street, N. E., Atlanta.

Civil Defense Item: A splendid film entitled "They Also Serve" produced by the Jam Handy Organization, is available for use. It shows actual pictures of many recent disasters including Texas City explosion and fire, New York Harbor naval disaster, Miami and New England hurricanes, and Japanese earthquakes. Address Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10, Ill. Other films teaching basic principles of First Aid may be obtained from Encyclopedia Britannica Films, Inc., Wilmette, Ill. Titles: Extensive Burns, Control of Bleeding, Care of Wounds, Splinting a Fracture, Control of Bleeding, Artificial Respiration, and Treatment of Shock.

Georgians note with pride that the first nurse assigned to Iran under the Point Four Program is our own Miss Ruth Johnson, R. N., of Valdosta, who trained at the Grady Hospital School of Nursing in Atlanta. Her experience in Public Health nursing has included assignments in Japan, Greece, Egypt and Panama.

Dr. Lawrence Lee, Jr., Secretary, states that a called meeting of the Georgia Medical Society was held on June 5 to organize the Physicians' Service Association of Savannah.

Suggestion for Society meetings in Summer: The Carroll-Douglas-Haralson Medical Society held its quarterly meeting at the Flying S Ranch, Villa Rica, on June 6. Fishing, swimming, horseback riding, and even plane rides were available to say nothing of the excellent barbecued pork, beef and chicken. No scientific program was held according to Dr. D. S. Reese, secretary.

What with MacArthur, Marshall, Bradley, Acheson, et al., taking the "spotlight" all medical legislative problems in Washington seem to be dormant for the moment according to the Lawrence copies of Capitol Clinics.

Draft News: Because of the small number of volunteers for the Armed Services, the Selective Service System will have to provide 1,202 doctors in July, August and September. Officials have made several points clear: 1. Men selected for drafting will be notified in time to apply for reserve commissions. Local Selective Service boards will have Defense Department Form 390 for those who previously indicated they were not interested in a reserve commission but who might now want to apply. Boards also will expedite processing of men who previously indicated they wanted commissions. 2. Within the priority, age will determine the order of call-up, with the youngest going first; the same system applies to reserve officers. 3. Priority I physicians classified 1-A may apply for a reserve commission, thus avoiding induction by Selective Service and assuring an extra \$100 monthly pay, but this will not mean a delay in going on active duty. Either as reserves or draftees, 717 Priority I physicians will enter Army or Air Force in July, another 333 in August and 152 in September. 4. Selective Service plans to allot state quotas based on the proportion of Priority I men in the state to the national total. However, as the number of reserves commissioned increases, the number to be drafted will decrease proportionately, both nationally and by state.

Medical Education Item: The National Fund for Medical Education to help the nation's hard-pressed medical schools was launched recently in New York with former President Herbert Hoover, as honorary chairman of the fund, and many of the nation's most prominent people as members. If our medical schools are to operate without participation by the Federal government, we must support this program with our DOLLARS—have you sent in your contribution for 1951?

From North Carolina and Florida: Over 900 physicians attended their Annual Sessions this year. With about the same membership can't Georgia do as well in Atlanta May 11, 12, 13 and 14 next year?

There were 209,040 physicians in the United States as of Dec. 15, 1950 according to a tabulation of figures in a recent issue of The Journal of the American Medical Association. Two hundred twenty-five new doctors were licensed to practice medicine in Georgia last year compared with 1,356 in California; 1,161 in New York, and 752 in Texas.

The Ninth District Medical Society held its Spring meeting at Lakemont on May 16 as the guests of Drs. J. K. Burns and Bruce Schaefer with over 100 in attendance. Scientific papers were presented by Drs. Peter B. Wright and Hervey M. Cleckley, both of Augusta. Dr. E. A. Roper, Jasper, was elected president; Dr. Hartwell Joiner, Gainesville, secretary; Dr. Robert T. Jones, III, Canton, subcommittee on Public Health and Dr. Marcus Mashburn, Sr., Cumming, subcommittee on Public Policy and Legislation. The Ninth District will hold its next meeting at Jasper in September.

Dr. Thomas E. Reeve, Jr., Carrollton, attended the annual Frank E. Bunts Institute Continuation Course in Surgery, Cleveland Clinic, Cleveland, Ohio, in the early part of May.

The Georgia Industrial Surgeons Association was reactivated at the Augusta meeting of the Medical Association of Georgia. Officers elected were Dr. J. W. Simmons, Brunswick, president; Dr. Joseph C. Read, Atlanta, vice-president; Dr. A. M. Collinsworth, Atlanta, secretary-treasurer. The Executive Committee is composed of the past presidents: Dr. C. F. Holton, Savannah; Dr. B. H. Minchew, Waycross, and Dr. R. L. Rhodes, Augusta.

Dr. Walter W. Daniel, Atlanta, was named chairman of the Health Division, Atlanta Planning Council recently. Mrs. Edgar Dunstan was elected secretary and Mrs. Shelley Davis, Dr. Joseph Massee, Dr. J. F. Hackney, Dr. R. W. McGee, and Dr. T. O. Vinson are members of the Executive Committee.

Dr. Edgar D. Shanks, Jr. announces that after July 1 he will be associated with his father, Dr. Edgar D. Shanks, in the practice of internal medicine. His offices will be in the Doctors Building, 478 Peachtree Street, N. E., Atlanta.

The Annual Clinical Congress of the American College of Surgeons will be held in San Francisco, November 5-9. The Annual Congress of the Pan-Pacific Surgeons Association will be held in Honolulu the following week beginning, Nov. 12. Those doctors interested in a special vacation trip, including one or both meetings, should write to Mr. J. M. Born, 93-B Forsyth St., N. W., Atlanta, for details. It will not be necessary to travel in groups and you can arrange your own schedule.

The Southern Medical Association meets in Dallas, Texas, November 5-8. Dr. Olin S. Cofer, Atlanta, is a Councilor representing our area. Dr. Robert C. Pendergrass, Americus, is vice-chairman of the Section on Radiology; Dr. A. M. Phillips, Macon, vice-chairman, Section on Proctology; Dr. Harold P. McDonald, Atlanta, Secretary, Section on Urology, and Dr. David A. Davis, Augusta, chairman of Section on Anesthesiology.

Dr. John W. Turner takes pleasure in announcing the association with him of Dr. August B. Turner in the practice of general surgery at 151 Ponce de Leon Avenue, N. E., Atlanta.

All Atlantians, particularly those in the medical profession, were deeply saddened upon learning of the tragic and untimely death of our own Caroline Pratt on May 22, at Fernandina, Fla. Even though she had been in Atlanta only a few years during which time she had done outstanding work both for the Red Cross and Communicable Disease Center, she had endeared herself to everyone with whom she came in contact. Our deepest sympathy goes to her husband and children—need it be added that a greater sacrifice could never be made.

The Arthritis and Rheumatism Foundation is offering research fellowships in the basic sciences related to arthritis. Fellowships will be granted at both the predoctoral and postdoctoral levels. The predoctoral fellowships will range between \$1,500 and \$3,000 per annum, and the postdoctoral from \$3,000 to \$6,000. The deadline for these applications is November 15, 1951. Application forms may be obtained by writing the Medical Director, Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, N. Y.

Medical College of Georgia News: Dr. Louis Manganiello has accepted an appointment as Assistant Professor of Neurological Surgery, Medical College of Georgia, Augusta, effective April 15, 1951.

Doctor Manganiello, of Waterbury, Conn., received his A.B. degree at Harvard College, Cambridge, Mass., and his M.D. degree at the University of Maryland School of Medicine, Baltimore, Md., in 1942. He interned at the University Hospital in Baltimore and volunteered for Navy service in 1943. After thirty-nine months of active duty, he was released to inactive duty with the rank of Lieutenant (Senior Grade). He then completed four years of Neurosurgical training. In 1950 he accepted the position as full time instructor in Neurosurgery and Neuro-anatomy, University of Maryland School of Medicine in Baltimore and also served as Consultant Resident at University, Mercy and City Hospitals of that city. In June 1950, Dr. Manganiello was married to Dr. Carol Graham Pryor, Newington, Ga., a graduate of the Medical College of Georgia, in the class of 1947.

Doctor Manganiello is a member of the American Medical Association, Medical and Chirurgical Faculty of Maryland, the Baltimore City Medical Society, American Psychiatric Association, Eastern Association of Electro-Encephalographers, American Cancer Association, Diplomate of the National Boards of Medical Examiners, and a member of the Phi Beta Pi Medical Fraternity.

Seventy-four senior students of the Medical College of Georgia received their Doctor of Medicine degrees in the graduation exercises on June 4. A Master of Science degree and a Master of Science in Medical Art degree were also awarded.

The graduation address was delivered by Dr. William A. Boyd, of Columbia, S. C., who admonished the doctors that the fight against socialized medicine must be continued. He stated that the best way to fight socialized medicine is for the medical profession to examine its own faults and to return to the principles of service and human consideration that characterized the profession in its earlier days.

Dr. Boyd also stressed the great need today for general practitioners in the field of medicine.

Dr. G. Lombard Kelly, President of the Medical College, administered the Hippocratic Oath to the graduates. Lt. Col. Jules J. McNerney presented commissions in the Army and Air Force to 22 members of the graduating class.

Dr. Amey Chappell, Atlanta, was elected president of the American Medical Women's Association which concluded its 36th annual meeting at Atlantic City, June 10. Dr. Chappell formerly served as director of the South Atlantic area of the Association.

Dr. Paul B. Beeson, Atlanta, professor of medicine, Emory University School of Medicine, and Dr. Perry P. Volpitto, Augusta, professor of anesthesiology, Medical College of Georgia, were among the 12 American physicians forming the medical education mission for Japan. Headed by Dr. Beeson, the group approved by the Supreme Commander of Allied Forces, will spend six weeks visiting 12 Japanese medical schools.

Are you in agreement with Dean Murphy's (Franklin D. Murphy, M.D., Dean of the School of Medicine, University of Kansas) article in the recent Saturday Evening Post entitled "We Need More Doctors"?—send in your comments.

Dr. Edward McMichael West announces that after July 1 he will be associated with his father, Dr. C. M. West, in the practice of internal medicine. His offices will be in the Candler Building, Atlanta.

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FAT METABOLISM AND ARTERIOSCLEROSIS*

CHAS. F. WILKINSON, JR., M.D., New York

From the standpoint of morbidity and mortality arteriosclerosis is probably the most important disease problem in this country today. Of the several types of arteriosclerosis, atheromatosis is by far the most important. This talk will deal only with atheromatosis or atherosclerosis. It is a disease of the intima and is most commonly seen in the aorta, but is also found with distressing frequency in the cerebral, coronary and renal arteries.

The characteristic lesion of atherosclerosis is a subintimal collection of lipid-laden foam cells. This lesion may enlarge by the accumulation of more foam cells, may become necrotic and ulcerate through the overlying intima, or may slowly regress, the foam cells being replaced by varying amounts of connective tissue. Though the life history of the characteristic fatty plaque is known with reasonable certainty, the exact mode of genesis is still obscure. Leary¹ has proposed a theory that the atheromatous process is the result of a direct invasion of the intima by macrophages containing lipid material. These cells he called lipophages and states that he has demonstrated all stages of this intimal invasion. This theory has been questioned by some who feel that the lipid, whether as lipophages or not, enters the intima by way of the vasa vasora. On the other hand, Duff^{2,3,4} has brought forth evidence that the primary lesion is an alteration of the ground substance of the subintima, which is followed by the appearance of lipid material and finally the local accumulation of phagocyte cells.

It should be pointed out that atheromatosis is not a process that is necessarily associated with old or middle age. It does occur in younger individuals. My associates and I⁵ have reported a case of a girl nine years old with angina pectoris which presumably was due to advanced atherosclerosis. We must remember that all of the experimental methods for producing atheromatosis, work as well in the young and middle aged animals as they do in the older animal. Holman⁶ has shown that even in very old and far advanced atheromatous lesions, one can

pick out lesions of very recent origin. We then come to the conclusion that the development of atheromata is an episodic process. The fact that it occurs more commonly in older than in younger people may be the result of an accumulation of lesions over a period of years rather than being due to a process that is associated with old or middle age.

The atheromatous lesion is largely composed of cholesterol^{7,8} and the tremendous amount of evidence that atheromatosis is in some way related to cholesterol metabolism may be regarded as conclusive. However, there is equally good evidence that a metabolic abnormality of the sterol cannot account for all the phenomena observed in this disease⁹. For example, the well known patchiness of the disease makes it necessary to postulate the operation of local factors in addition to the general metabolic "predisposition". Despite these reservations, the importance of cholesterol metabolism in the genesis of atherosclerosis must still be conceded.

During recent years, data which appeared contradictory has begun to fit in to some sort of a pattern and while the picture is far from complete, we can at least feel encouraged that headway is being made toward the solution of the problem. In spite of this headway, there are still many points that are highly controversial. The relative roles of dietary intake, the synthesis of cholesterol within the body, the physical state of the blood lipids, and the destruction and excretion of cholesterol are either uncertain or lack general acceptance.

Because of the complexity of this subject, I should like to discuss it under several headings, the first one being:

SYNTHESIS OF CHOLESTEROL IN THE BODY

There is a great deal known about the synthesis of cholesterol in experimental animals. Bloch and Rittenberg¹⁰ have shown that in the rat most of the cholesterol is formed from acetate and water. They have also shown that it is unlikely that fatty acids are directly involved in cholesterol synthesis.

It has been shown¹¹ that the rate of synthesis in the body is to some extent dependent upon the amount of cholesterol in the diet. Thus if excessive cholesterol is added, the amount

*Presented as the second William C. Warren Memorial Lecture, Emory University Medical School, Atlanta.

From the Department of Medicine, New York University Postgraduate Medical School, New York City.

of endogenous cholesterol produced is decreased. If the dietary cholesterol is reduced, endogenous synthesis is increased.

The exact mechanism of cholesterol formation in the human is not known. It has been shown, however, that it can be synthesized. In 1920 Gamble and Blackfan¹² showed that there was a greater output than intake of cholesterol in the infant and concluded that it was synthesized in the body. This has been confirmed by other investigators in the adult.

It has also been shown that diets in which cholesterol is low or almost absent do not have any effect on the blood cholesterol of normal people.

Even in certain types of hypercholesterolemia, diets in which cholesterol is low or almost absent have no effect on the ability of the body to maintain elevated levels of cholesterol in the blood^{13 14}.

It appears certain, therefore, that the human organism can synthesize cholesterol, and except in certain highly artificial situations, can maintain normal or even elevated plasma levels.

ABSORPTION, DESTRUCTION AND EXCRETION OF CHOLESTEROL

One cannot discuss the synthesis of cholesterol without discussing its absorption, destruction and excretion.

Cholesterol can be absorbed from the gut by either the herbivorous or carnivorous animal and the ability to absorb cholesterol is enhanced by the presence of fat in the gastrointestinal tract.^{15 16} The herbivorous animals cannot excrete it as readily as the carnivorous one. In fact it can be shown that herbivora excrete very little cholesterol¹⁷. This inability to excrete cholesterol after it has been absorbed explains why the blood cholesterol in rabbits can be raised so rapidly by adding it to the diet. From this we must conclude that there are at least two different ways in which cholesterol is metabolized by various animal species.

Neither dihydrocholesterol or coprosterol (Figure 1) can be reabsorbed from the gut. Coprosterol can be formed from cholesterol in the gut. This would be one way in which cholesterol formed in the body and excreted into the gut could be made unavailable for reabsorption by the organism. Dihydrocholesterol can be formed in the body and excreted into the gut. The inability of the herbivora to do this as readily as the carnivora may explain many species differences in cholesterol tolerance.

All of this emphasizes the difficulty one has in translating conclusions derived from animal experimentation in cholesterol metabolism to man until more is known about fundamental cholesterol metabolism in man.

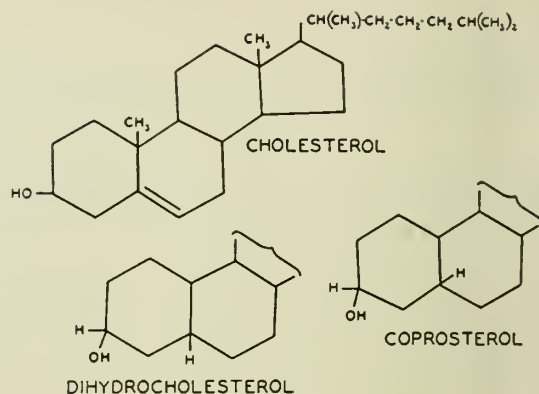


Fig. 1. This shows the close structural relationship between cholesterol, dihydrocholesterol, and coprosterol.

DIETARY INTAKE OF ANIMAL FAT AND CHOLESTEROL

During recent years it has been thought by many that the blood cholesterol level has some effect on the development of atheromatosis. It is thought by Dock¹⁸ as well as others^{19 20 21} that the amount of cholesterol in the diet is a factor not only in the production of atheromata, but also in determining the concentration of cholesterol in the blood. Doubt^{13 22 23 24} has been expressed by others as to the importance of ingested cholesterol as a controlling factor of the blood level, and also as to its etiological significance in atherosclerosis.

Many of the assumptions of those favoring a dietary factor in the production of atherosclerosis have been based on the fact that certain races of man have less atheromatosis than other races, and that they also ingest less cholesterol and animal fat. Any comparison of this type is difficult, and since so many other variables, both known and unknown, are present, conclusions may be fallacious.

In a recent study²⁵ as many as possible of these variables were kept constant. Most of the people studied lived in rural areas but approximately 20 per cent lived in cities. All had economic freedom of choice. Meals were planned, cooked, and served by one person, the housewife, in each of the several groups. The study was carried on long enough to rule out seasonal variation. The groups studied were told not to change their eating habits, and to record everything they ate.

The group studied was a large kindred (or family group) extending over four living generations. An inherited metabolic defect (essential familial hypercholesterolemia)⁵ was present. This defect was of such a nature that the blood cholesterol was increased in some members of the family, and was increased in two different degrees. In one group with increased blood cholesterol levels xanthoma tuberosum was pres-

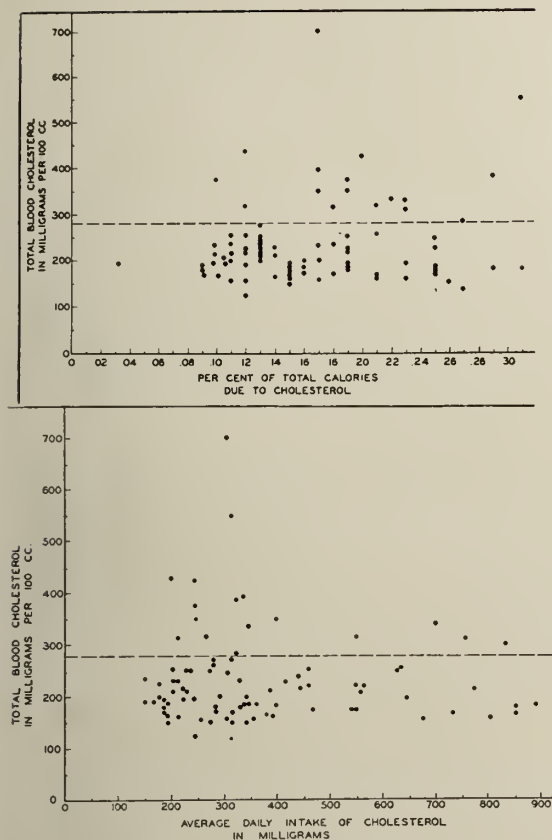


Fig. 2. These two graphs show that there was no relation between total cholesterol intake or per cent of total calories due to cholesterol and the blood cholesterol. Similar graphs were constructed for carbohydrate, fat, and protein.

ent and the incidence of atheromatosis was high. The other group with increased blood cholesterol did not have xanthoma tuberosum and it was not possible to show that the increased blood cholesterol had any effect on life expectancy, nor was the incidence of complications reported to be associated with a high blood cholesterol increased significantly.

It was shown that the level of the total blood cholesterol was unrelated to the absolute amounts of carbohydrate, fat, protein, and cholesterol in the diet and there was no relation between the relative amounts of these dietary constituents and the total blood cholesterol level (Figure 2). After these experiments were done, more detailed studies were performed where the individuals were asked to vary their diet over a long period of time¹⁴. With rather wide variations in the intake of naturally occurring foods plus the addition of such lipotropic substances as choline and lecithin we were unable to affect a significant change in the blood cholesterol level (Figure 3).

This does not mean it has been proven that exogenous lipids have little or nothing to do with atheromatosis. On the other hand this

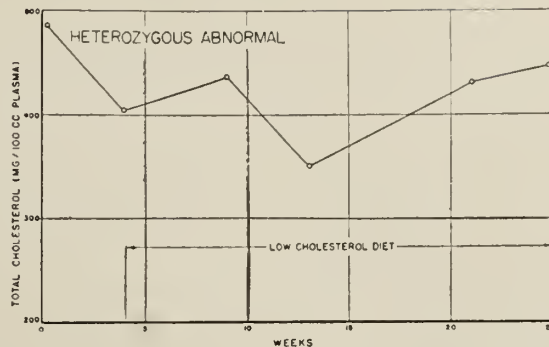


Fig. 3. It can be seen that while the blood cholesterol varied it showed no definite trend during the period of restricted cholesterol intake.

work does give additional support to that school of thought.

Shaffer²⁶ has reported some interesting data after analyzing the autopsy findings of 100 cases between 47 and 65 years of age that had been on diets abnormally high in cholesterol for the treatment of peptic ulcer. He found that the incidence of coronary arteriosclerosis was no greater than in 100 control cases that had been on diets much lower in cholesterol.

Wilens²⁷ has shown that the substitution of alcohol for a large portion of ordinary foods in the diet does not have, in itself, an appreciable effect on the development of atherosclerotic lesions. He also emphasizes that the materials deposited in atheromatous lesions are not necessarily derived as such from ingested food. He points out that in excessive alcoholism average body weight is usually maintained and the liver contains large amounts of fat, suggesting that much of the alcohol consumed was converted into fat.

So far, we have been discussing variations in diets as ordinarily consumed. Or to put it another way, variations in diet that are practical as far as a patient is concerned. There have been two very interesting experiments where the diet was varied to an extreme degree.

Mellinkoff²⁸ in 1950 reported the results of an experiment where patients were fed a completely synthetic diet. This diet consisted entirely of protein hydrolysate and dextrimaltose. He found that under this regimen, it was possible to reduce the blood cholesterol and to reduce it significantly. This in spite of the fact that all patients either gained or maintained weight on this regimen. Vitamins and ferrous sulfate were administered but no other medications were given that one would normally suspect of affecting the blood cholesterol. Not all of the patients under this therapy had a reduction in their blood cholesterol, but the majority of them did have a significant reduction.

It is possible, because of the complete absence of fat, that the cholesterol present in the

bile could not be reabsorbed and the negative cholesterol balance was of such a degree that endogenous synthesis could not maintain normal blood levels.

Steele²⁹ and his group carried their experiment to the other extreme. They fed dried egg yolk in large amounts to patients and found that it was possible to elevate the blood cholesterol. It is of interest to note that when cholesterol in its pure form was added in even greater amounts than the amount present in egg yolk, no elevation was affected. In addition, pure cholesterol plus added fat did not increase the blood cholesterol as did the dried egg yolk. It must be pointed out also that the amount of egg yolk administered was well above that consumed in an ordinary diet and that while the increases in blood cholesterol were very definite, they were not excessive.

PHYSICAL STATE OF THE BLOOD LIPIDS

The demonstration by Hueper³⁰ that injection of macromolecular colloids other than cholesterol could produce the histologic picture of atheromatosis naturally excited the suspicion that the stimulus to atheroma formation lay not in the chemical structure of cholesterol but rather in its physical state.

Moreton^{31, 32} has recently advanced a theory that the physical state of the blood lipids is the cause of arteriosclerosis. He has reported that people with nephrosis, myxedema, xanthomatosis and other diseases which predispose to arteriosclerosis have an increased number of "chylomicrons" even in the fasting state, and that polyvinyl alcohol and the other substances used by Hueper are also in large particles or "chylomicrons" after injection.

His theory is that large lipid particles which pass with the lymph into the intima incite the foreign body response which is a characteristic histological feature in early experimental atheromatosis. He believes the triglycerides and fatty acids are rapidly resorbed or metabolized and cholesterol being more inert remains behind and accumulates in the slowly developing lesion. He contends that the accumulation of lipids in the arterial intima is a local mechanical problem and is unrelated to general body balance or over-all metabolism of the body lipids.

Bevens, Kendall, and Abell³³ have produced atheromata by repeated injections intravenously of cholesterol suspensions. They noted microscopic evidence of lipid within the intima of the aorta 3 hours after a single injection. They did not, however, report the particle size of their cholesterol suspensions.

Pollack³⁴ showed that subintimal cholesterol deposits could be demonstrated immediately upon the completion of injection of cholesterol suspensions and that the number of lesions were larger upon injecting coarse suspensions than finely dispersed cholesterol. He also reported that the number of atheroma-like lesions de-

creased if the experimental animal were allowed to survive after a single injection.

Still more recently, Gofman³⁵ has shown that in many cases of experimental and human arteriosclerosis there is an increase in a certain class of lipoprotein molecules. These molecules are characterized by their rate of flotation in the gravitational field of the ultracentrifuge. This data, while extremely impressive, by no means gives an absolute correlation between the incidence of arteriosclerosis and the presence of these particular lipoprotein molecules. He has also reported that the numbers of these molecules could be reduced by diets low in fat and cholesterol.

Within the past several months Barr³⁶ has brought forward new evidence that the physical state of the lipid is important. He has shown that the ratio between the alpha and beta lipoproteins is definitely shifted in diabetics which are presumably predisposed to arteriosclerosis. It should be pointed out that the level of the blood cholesterol did not necessarily correlate with the altered physical state of the blood lipids as measured by the methods of Barr or Gofman.

INTERRELATION OF THE BLOOD LIPIDS

Since the ratios of the various blood lipids are altered in certain disease states and normally change after meals it is not surprising that some investigators have studied these variations in relation to the formation of atheromata. This led to inquiries into the mechanisms which maintain the normally finely-dispersed colloidal suspension of this hydrophobic lipid in serum. At least two factors would seem to be of importance in this respect (1) plasma proteins which have been discussed, and (2) plasma phospholipids.

The major phospholipid of plasma is lecithin, which is hydrophilic in contrast to the other plasma lipids, and is capable of stabilizing oil-in-water emulsions³⁷. In 1949, Ahrens and Kunkel³⁸ were able to show that the concentration of phospholipid was an important factor in determining the particle size of serum lipids.

Kellner and his associates have reported that the repeated intravenous injection of either Tween 80 or Triton A-20 into rabbits fed a high cholesterol diet, retarded or prevented the development of atherosclerosis³⁹. This was in spite of the fact that rabbits given the intravenous detergents had far higher mean levels of the blood cholesterol than the control animals, which were also fed cholesterol but did not receive the detergents.

The critical factor in this experiment seemed to be not the level of the blood cholesterol, but its proportionate relationship to the phospholipids in the blood. When the phospholipids were elevated to the same degree as the cholesterol the incidence and severity of atherosclerosis

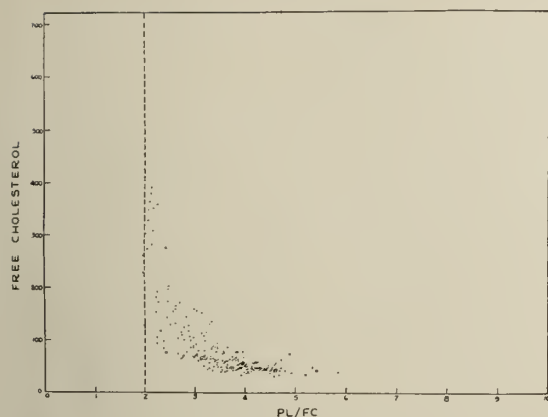


Fig. 4. This illustrates the limiting value of a PL/FC ratio of 2.00. This value represents an equimolar concentration of phospholipid and free cholesterol.

was decreased. If, however, the phospholipid did not parallel the rise in cholesterol, there was rapid production of atheromata. No such protection was noted if the detergents were given by mouth, and intravenous detergents were ineffective in the resorption of atheromata previously produced by cholesterol feeding.

Duff and his co-workers⁴⁰ have shown that diabetes produced in rabbits by alloxan actually inhibits the formation of atheromata. This, of course, is directly opposite to the commonly accepted idea that human diabetes causes an increase in the incidence of atherosclerosis.

The neutral fat in the diabetic rabbits showed a much greater rise in proportion to the increase in total cholesterol than it did in the control rabbits.

In 1950 a group of us⁴¹ reported on the relationship between the phospholipids and the cholesterol in plasma on the basis of the examination of 242 human subjects, including both normal controls and a variety of disease states. A most consistent relationship was found to exist between the phospholipids and free cholesterol which appeared to be independent of the disease process. No such relationship could be demonstrated between phospholipid and total or esterified cholesterol.

With elevation of the free cholesterol, there is a decrease in the proportionate amount of phospholipid. The rate of decrease, rapid at first approaches zero when the PL/FC ratio has declined to the point where equimolar quantities of phospholipid and free cholesterol exist. Further increases in free cholesterol do not disturb this equimolar relationship (Figure 4).

Since the ratio of free cholesterol and phospholipid can be predicted on the basis of the total cholesterol level, in the absence liver cell failure, neither this ratio, nor the total cholesterol-phospholipid ratio seem to be of any more value than the height of the blood cholesterol

in determining whether a patient is likely to have atheromatosis or not. It has been pointed out⁴² that the heights of the blood cholesterol cannot be used to separate individuals with atheromatosis from those without it. We do feel however, that this limiting factor of the unimolar ratio may be important in intimal metabolism of lipids and the sequestration of cholesterol in the formation of plaques.

With this evidence in front of us it appears reasonable to say that the interrelationship of the blood lipids is important in experimental atheromatosis and possibly in human atheromatosis; and through an understanding of this and the physical state of the blood lipids we may finally arrive at our goal, which is the prevention and treatment of arteriosclerosis.

METABOLIC AND MECHANICAL FACTORS IN ARTERIOSCLEROSIS

There can be no doubt that the state of the body metabolism has a great deal to do with the development of atheromata. It would be impossible to cover all the material available on this subject and I shall, therefore, select only a few examples.

Wilens⁴³ has shown that atherosclerosis is more likely to develop in obese than in underweight people. He has also shown that the process can be reversed to some extent by a reduction in weight⁴⁴.

Diabetes and myxedema are known to be associated with an increased incidence of atherosclerosis. Stearns⁴⁵ and his co-workers have reported that 75 per cent of 50 diabetics at autopsy showed significant coronary artery disease and 1/3 of them died of acute coronary occlusion. They feel that diabetic women over forty are as likely to have coronary atherosclerosis as are men and that diabetics have coronary artery occlusions twice as often as non-diabetic men and eight times as often as non-diabetic women.

On the other hand Underdahl and Smith⁴⁶, in reviewing the records of 95,000 women under 40 seen at the Mayo Clinic over a 10 year period, found only 27 with unequivocal evidence of coronary artery disease, and of these only one had diabetes. They felt that obesity, hypertension and hyperlipemia were the conditions nearly always associated with coronary atheromatosis in women under 40.

Bruger and Chassin⁴⁷ in 1940 reported that the hypertensive state leads to an increased deposition of cholesterol in the renal arteries. Faber²⁷ has demonstrated the same phenomenon in the aorta. Wilens⁴⁸ has recently favored a mechanical theory, with thickening of the intima as the initial lesion and hypertension actually aiding in the formation of plaques.

Ophuls⁴⁹ has shown the extreme importance of the existence of nephritis in young individuals who have atherosclerosis. In his series of those that had arteriosclerosis below the age of 30, more than one half of them were nephritic.

There are certain inherited metabolic disorders that are associated with an increased blood cholesterol. Some of these individuals have atheromatosis early in life but some do not. Here again, much more must be known about fundamental cholesterol metabolism in the human before many apparent contradictions can be reconciled.

SUMMARY AND CONCLUSIONS

1. Cholesterol can be manufactured by the body in large amounts.
2. Except in certain metabolic disorders, the level of the blood cholesterol is affected only by extreme changes in the diet.
3. Hypercholesterolemia, per se, is probably not the cause of atheromatosis.
4. The physical state of cholesterol and the other blood lipids seems to be an important factor in the production of atheromata.
5. Experimentally, the interrelation of all the blood lipids appears more important than the concentration of any single one.
6. Atheromatosis should be thought of as an episodic, intermittent and cumulative disease. The fundamental underlying process can occur at any age.

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Britain's Health Service Three Years Old. Britain's national health service celebrated its third birthday last week, with a half million patients on hospital waiting lists and more than 10,000 tuberculosis cases seeking admission to sanatoria. Since the service started in 1948, druggists have dispensed an average of five prescriptions a year for every man, woman and child in the country. During the current year, nationalized medicine will cost Britain about 1.3 billion dollars. Lack of resources and money is becoming a bigger problem for the socialistic Labor government, however.

DIABETES DETECTION IN GEORGIA

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Physicians interested in diabetes have long been aware of the increasing importance of this disease in the American population. The founding of the American Diabetes Association in 1940 gave rise to the hope that through co-ordinated effort the million or more previously unknown diabetics could be discovered. The war delayed the undertaking, but late in 1948, after a few pilot surveys, large scale diabetes detection really began.

Early in 1949, Dr. James E. Paullin sought the aid of the Georgia State Board of Health in finding these diabetics. Since 1942, the State Health Department had been experimenting with mass surveys for tuberculosis and syphilis and was well acquainted with the problem of handling great numbers of people in a short time. Therefore, it was quite logical to call upon their knowledge and experience to help conduct a mass diabetic survey. Because many diabetics have been found to have a high renal threshold it was decided that a blood test would be far more accurate than urinalysis for discovering the presence of diabetes. The importance of this has been borne out in later tests when it appeared that 5.4 per cent of those with abnormal blood sugars had no glycosuria following the administration of glucose for a glucose tolerance test, and 40 per cent of those in the borderline group had no glycosuria.

The Anthrone method of blood sugar determination developed by Dreywood¹ and modified by Durham, et al.² at Emory University, was considered most suitable for rapid screening of large numbers of people. By this method four groups, or classifications, of blood sugar levels were established:

Blood Sugar Levels

Mg. Sugar per 100 cc. of blood	
Group 1	Below 130
Group 2	130-169
Group 3	170-199
Group 4	Over 200

The Anthrone sugar test is a true carbohydrate test and eliminates other reducing substances in the blood. Therefore, the readings are between 10 and 30 mg. per cent lower than those obtained by the method of Folin and Wu. The adoption of Folin and Wu standards, therefore, means that the findings reported in this paper are very conservative. It may even be necessary to lower the standards. Tests were first run in Twiggs and Lowndes Counties in conjunction with chest x-ray and serology studies

previously scheduled. Blood and urine sugar concentrations of 749 individuals were checked to prove the adaptability of the test to large scale screening. Thus, it was found that 100 individuals per hour could be tested without difficulty and the results obtained were identical with other more involved tests for true carbohydrate concentration in the blood.³

At first, an individual was referred to the physician of his choice if the blood sugar level exceeded:

1. 170 mg. per 100 cc. of blood regardless of dietary history, or
2. 130 mg. per 100 cc. of blood 4 or more hours since the last meal or snack.

It was soon discovered that very few people remembered just when they had last had anything to eat, and consequently many were needlessly referred to the family physician because of a supposedly fasting blood sugar level of over 130 mg. per cent. It was then decided that a confirmatory glucose tolerance test should be incorporated for use with patients who revealed an abnormal blood sugar level.

Having established the ability to run accurate tests quickly and on a large scale, a diabetes case finding program was incorporated into the Greater Atlanta Screening Survey. In a period of 76 days, during which the transportation strike seriously cut down the number of persons tested during the strike, nearly a quarter of a million individuals were checked for such conditions as syphilis, anemia, diabetes, obesity, lung pathology and gross cardiac abnormalities detectable on x-ray, and examinations were made of the mouth and teeth.

From the diabetic standpoint, the results of this program showed:

Total tested:	211,639
Total normal:	204,588
Total abnormal:	7,051 (3.3%)

Since the detection program was inaugurated, screening surveys, which included diabetes detection, have been run in the following places:

County	Date	Days	Total Tested
Twiggs and Lowndes	Fall 1949	4	749
Fulton and DeKalb	Spring 1950	76	211,639
Morgan	Sept. 1950	6	7,376
Coweta	Oct. 1950	18	17,087
Washington	Nov. 1950	18	15,215
Glynn, McIntosh and Camden	Jan. 1951	18	24,075
Burke	March 1951	19	15,386

Total..... 291,527

More than 9,300 additional small scale studies done in industries or schools bring this total

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to over 300,000 persons tested since the inauguration of the Diabetes Detection Drive in Georgia. We have not attempted to give the total number of diabetics found in each of these places nor an average percentage for the entire survey because frequent changes were necessary in an effort to improve technic and standards. The changes have generally been pointed at being ultraconservative in interpretation. With each large section of the state tested, more and more details have been found, some of which are at variance with older beliefs about diabetes and many of which will require much further study and analysis.

The last completed survey, for which results are available, is the tri-county survey made at Brunswick from January 10 to 30. In a period of 20 days a total of 24,075 persons were screened. The results of completed tests are as follows:

	<i>Tested</i>	<i>Abnormal Blood Sugar</i>
White males	5,709	71 (1.24%)
Colored males	5,255	63 (1.2%)
White female	6,565	69 (1.04%)
Colored females	5,836	134 (2.3%)

This shows an apparently high incidence of diabetes in the colored female. Breaking down this total a little further we find that age grouping, as we have already known in the past, does make quite a difference in the incidence of abnormal blood sugars.

UNDER 30 YEARS OF AGE:

	<i>Tested</i>	<i>Abnormal Blood Sugar</i>
White males	2,402	4 (.16%)
Colored males	2,685	4 (.15%)
White females	2,869	4 (.14%)
Colored females	3,048	7 (.23%)

AGE 30 TO 40 YEARS:

	<i>Tested</i>	<i>Abnormal Blood Sugar</i>
White males	2,213	28 (1.27%)
Colored males	1,616	22 (1.37%)
White females	2,605	24 (.92%)
Colored females	1,779	48 (2.8%)

AGE 50 AND OVER

	<i>Tested</i>	<i>Abnormal Blood Sugar</i>
White males	1,074	39 (3.6%)
Colored males	951	37 (3.9%)
White females	1,071	41 (3.8%)
Colored females	1,004	79 (7.9%)

The unusually high percentage among colored females as observed here was completely unanticipated by us. The question now arises as to whether the high rate of 7.9 per cent means a true racial and sex difference. These figures have not yet been subjected to critical statistical analysis. The trends indicated by some of our figures are rather startling and for the present it is necessary to accumulate more corroborative

evidence before accepting these findings at their face value.

We feel that the screen tests as run here in Georgia are as thorough and reliable as any in the entire country. Eventually, all counties in the State which desire the Screening Survey can be given this service. To secure a survey in any county it is necessary that the local Board of Health request such a survey and pay 10 per cent of the cost. This is the comparatively small sum of about ten cents per person tested including all tests. The entire screening survey, including x-ray of the chest, all blood studies and reports to the individuals tested are done at a cost of approximately \$1.00 per person. After the test is made, patients with abnormal findings are advised to seek the aid of the family physician for diagnosis. No diagnosis of any kind is made at the screen center. For example, in the diabetic screening test, notation is made only that the individual has an abnormality of carbohydrate metabolism. It is up to the local physician to interpret the findings, do any confirmatory tests he deems necessary, and then proceed with the proper treatment for his patient. It is requested, however, that the physician report his final diagnosis to the Department of Public Health on the forms provided for this purpose.

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First \$10,000 Criss Award Given for Work in Medicine. Because of their brilliant work in the development and use of Cortisone, Dr. Philip S. Hench and Dr. Edward C. Kendall of the Mayo Clinic were named joint winners of the first Mutual of Omaha \$10,000 Dr. C. C. Criss Award for outstanding contributions in the fields of public health and safety.

Presentation of the award was made at the meeting of the American Rheumatism Association at Atlantic City on June 9.

The Award is open to anyone in the field of public health or safety. It is, therefore, a real tribute to the great advances that have been made in Medicine that the first winners of the prize, second only to the Nobel prizes in cash value, should be won by workers in this field.

BIRTH CERTIFICATES FOR SCHOOL CHILDREN. Parents should obtain necessary birth certificates as soon as possible for children entering school next September, State Health Department officials have announced.

Most counties require that all children entering school for the first time must present birth certificates on the day of registration. The certificates issued for school use are "notifications of registration," and are issued free of charge. A charge of one dollar is necessary for certified copies of birth certificates, they explained.

THE MEDICAL CARE OF SERVICE CONNECTED DIABETICS IN GEORGIA

A. PARK McGINTY, M.D., Atlanta

In January 1949 under the direction of the dean's committee, four special clinics were established at the Veterans Administration Regional Office in Atlanta. These clinics were organized for the treatment of veterans with cardiac, pulmonary, gastrointestinal disease, and diabetes mellitus. Since its inception I have been the consultant for the diabetic clinic. The patients are veterans whose diabetes has been adjudged to be service connected. Prior to the establishment of this clinic, these diabetic veterans were followed by periodic questionnaires and were hospitalized when it seemed indicated.

This group of patients is unique in that most of them developed diabetes in early adult life. However, there are several elderly veterans who became patients of this clinic after the 81st Congress in 1950 passed Public Law 791 which declares that any disability incurred by a Spanish-American War Veteran may be considered to be service connected.

Table 1 shows the age distribution of this group. Fifty-nine are in the third decade; 53 in the fourth decade; 18 in the fifth; five in the sixth; one in the seventh; and six in the eighth decade.

TABLE 1			
<i>Age Range of 142 Patients</i>			
Age	No. Pts.	Age	No. Pts.
20-25	21	57	1
25-30	38	58	1
31-35	34	61	1
36-40	19	72	1
41-45	9	73	3
46-50	9	77	1
52-55	3	78	1

Table 2 shows the racial and marital distribution. All patients of this group are males and white married ones predominate.

TABLE 2	
<i>Racial and Marital Range</i>	
White	126
Colored	16
	142
Married	107
Single	35
	142

Figure 1 shows the geographical distribution of the communities throughout Georgia from which our patients come. Of the 142 patients, 31 reside in greater Atlanta; 30 reside outside Atlanta but within a radius of 50 miles; 44 are outside the 50 mile radius but within a radius of 100 miles; 11 are outside the 100 but within

the 150 mile radius, and only 26 reside beyond the 150 mile radius.

At intervals of about 3 months these patients are requested to report to the clinic on Tuesday morning between eight and nine without insulin or food. After a sample of blood and of urine are obtained they are given their injection of insulin and sent out for breakfast. During the morning they attend a class conducted by the dietitian, Miss Elinor Thompson who has been of inestimable aid in conducting the clinic. At intervals these veterans are examined in the dental clinic and any dental work indicated is authorized as an adjunct to service connected diabetes. After lunch they return for examination by, and individual discussion with the consultant, who prescribes any change in the diet or insulin. The patients are given necessary supplies and medicines from the drug room. Each month their insulin is mailed to them.

All of these patients had established diabetes when they were first called to this clinic and were on a prescribed diet. In case the diet was adequate it was not changed initially. However, there was confusion for the patients and for us since numerous systems had been used in calculating their diets and in instructing them. Therefore, this year, we have started re-instructing the patients using the booklet "Meal Planning With Exchange Lists" advocated by Committees of The American Diabetes Association and The American Dietetic Association in cooperation with Diabetes Branch—Public Health Service, Federal Security Agency. The dietitians at the Veterans Administration hospitals are also beginning to use this system. Therefore, in time we hope that veterans with diabetes will get essentially the same instruction whether they are in-patients or out-patients.

Table 3 presents data on the composition of our patients' diets. There is quite a range in each constituent but the average of the 142 diets gives a well balanced prescription, i.e. carbohydrate 212 Gm., protein 96 Gm., and fat 102 Gm. with an average total of 2150 calories.

TABLE 3		
<i>Composition of Diets</i>		
	Range	Aver.
Carbohydrate	110-300 Gm.	212 Gm.
Protein	50-140 Gm.	96 Gm.
Fat	50-138 Gm.	102 Gm.
Calories	1170-3080	2150

Table 4 presents a summary of the insulin used by these veterans. Only six of the 142 do not take insulin. At present no patient is taking multiple doses of regular insulin. Five are taking globin insulin and 39 are taking

veterans have had a minimal level below 70 mg. per cent, and that 86 have had a maximal level above 250 mg. per cent. In correlating the blood sugar level with the amount of glycosuria there seems to be a rather wide range in the renal threshold for glucose. A relatively few of the patients have shown a significant amount of acetone in their urine.

TABLE 4
Insulin Dosage

No. Pts	Type	Range	Aver.	*
6	None	0	0	0
5	Globin	27-70	50	3
39	PZI	14-70	36	6
25	Mixture	40-115	66	19
67	NPH	30-100	54	32
142		0-115	49	60

*No. Pts. Taking more than 50 units.

Cholesterol determinations have been made on the blood of 132 patients. They varied from 151 mg. per cent to 840 mg. per cent with an average of 257 mg. per cent. Sixty-three patients have had a reading above 250 mg. per cent. The patient with the high level of 840 mg. per cent had had previous determinations of 525 mg. per cent, 560 and 616 mg. per cent. He is showing evidence of progressive peripheral vascular insufficiency. About half of the patients with a high cholesterol level are receiving Methiscol but as yet we do not know how beneficial it will be. Priscoline, rutin and multiple vitamin capsules have also been prescribed when it was considered they might be beneficial.

The blood pressure determinations in this group have not been much higher than would be expected in a similar group of non-diabetic males. In considering the highest reading for

each patient we find the systolic pressure varied from 114 to 210 with an average of 145. The maximal diastolic pressure varied from 66 to 120 with an average of 84.

At the beginning of this clinic, a great many of the patients had not had enough instruction in the nature and care of their diabetes and many of them were poorly controlled. Almost every week during the first few months of 1949, we sent one or more patients to the hospital as an emergency because of diabetic acidosis. Now it is unusual for even milder degrees of acidosis, which do not require hospitalization, to be found. The general attitude of most of these patients is better, in fact, excellent. They are taking more interest in their condition and know more about it. This increased knowledge of diabetes has come from the two hour instruction period and other contacts made during each visit. Also each patient has been given his choice of a diabetic manual. However, even with distinct improvement, there are only a few patients who approach excellent control. The usual complications may be found in this group. Two World War I veterans have had amputations; three of the younger group have had coronary occlusions. One active case of tuberculosis was found. He and two others are now being followed, in conjunction with the chest clinic, as arrested cases. This clinic has not been in operation long enough and many of the patients have not had diabetes long enough for a detailed study of complications to be of significance. I would, however, like to state my belief that most of our patients are in better health now than they were when they first attended this clinic.

762 Cypress St., N. E.

MALE PSEUDOHERMAPHRODISM

THOMAS R. FREEMAN, M.D., *Savannah*

PRELIMINARY REPORT

In 1908, a canvas of the medical literature revealed 2400 cases of unclassified hermaphrodisism. Since that time many hundreds of additional cases have been reported, and accepted classification of types has been established.

It is not the purpose of this paper to discuss the many and varied genetic, environmental and hormonal influences on intersexuality, as suitable references are added below for this study. In reviewing the literature, however, a scarcity of facts concerning the effect of heredity on hermaphrodisism is noted. There are reports of as many as two siblings presenting hermaphroditic characteristics; and this has led a few investigators to mention that heredity may be a causative factor.

It is hoped that this preliminary report of a case of male pseudohermaphrodisism, with the history of additional members in the family similarly afflicted, may stimulate renewed interest in the subject; so that similar cases will be reported, and the role of heredity more thoroughly evaluated as a factor in the development of individuals with bisexual characteristics.

HISTORY

This 18 year old white "female" of American descent was referred to me in November 1950 because of the presence of two "knots in the groin". She wished to have these removed. She stated that they had been present as long as she could remember and had not interfered with her every-day activity, but were unsightly.

She had never been ill, except for the usual childhood diseases and had never consulted a physician.

Her delivery was a normal one performed by a physician; and her family was told she was a female. During her childhood she preferred rough games to dolls and more feminine childhood endeavor. She had both male and female playmates, but preferred the latter. In later childhood she enjoyed being outdoors, running about the farm in old clothes, rather than living a sedentary female childhood with usual interest in pretty clothes and housework. She went through the ninth grade in school, and always carried home a good report card. She quit school after missing several weeks because of bad teeth. During her school days she became very proficient at basketball.

At age 13, she developed pubic hair, and her breasts began to develop. She had never menstruated. There was no change in her voice. She had noted pleasurable sensations from fondling the breasts and clitoris, and masturbated on occasions. She began having dates at the age of 15 and "went steady" with two or three boys. She enjoyed petting parties but never attempted intercourse, because she thought it impossible.

During the past 14 months she worked in a factory operating small machinery with other girls. During that time she lived with two sisters and enjoyed keeping house.

Her father was a successful farmer and apparently had reared a happy and congenial family. She had 2 normal brothers, aged 27 and 11 and one normal sister, age 21. After much questioning she admitted that her other 4 sisters were "just like me". Their ages were 25, 23, 14, and 8. (I have recently examined one sister, C. J., aged 23. Her external genitalia were very similar to the patient reported herein). On her mother's side of the family there were: 7 other individuals showing similar abnormal characteristics. They were: 2 great aunts, 1 aunt, 3 first cousins, and 1 second cousin. (Efforts are being made to contact these people so that a comprehensive report of this family may be made at a later date).

PHYSICAL EXAMINATION

She was a fairly attractive "girl" of stated age. She was mentally alert, but somewhat timid. She was slender with long arms and legs and poor posture. Her general build was somewhat masculine, although the skin was soft, and the distribution of hair typically female. The Adam's apple was fairly prominent. The breasts were well developed and the areolae were typical of an 18 year old female. The head, neck, heart and lungs were essentially normal. The abdomen was flat, and no organs palpated. The pubic hair was normal; and there was no hair extending from the pubis toward the um-

bilicus. The labia majora were prominent and each presented an oval shaped mass measuring 3.5 by 2 cm., which could be moved freely to a position on the pubis where the external inguinal ring, typically male, could be palpated. The clitoris was prominent, measuring about 3.5 cm. in length and 1.5 cm. in width. It became turgid on palpation. Small elevations, one on each side, extended 1.5 cm. posteriorly from the posterior margins of the prepuce of the clitoris. These represented the labia minora. One inch posterior to the clitoris was a urogenital sinus with an introitus measuring 0.5 cm. in diameter. There was no hymen. This area remained moist at all times. This sinus was a blind pouch, 1 inch in depth. One half inch from its end, and on the anterior wall, is the urethral meatus. A catheter placed into this opening passed into the bladder. The catheter could be palpated through the anterior rectal wall in close proximity, except at one point where thickening was noted. This may have represented prostatic tissue.

Laboratory.—All routine laboratory work was within normal limits. Estroids and 17 Ketosteroids were within normal limits for either male or female.

Operation on December 15, 1950.—The abdomen was explored through a lower transverse incision. All organs in the abdomen proper were normal. The adrenals were palpated and were of normal size and consistency. The pelvis was typically male with no recognized female organs or remnants. Deep in the recto-vesical space, thickened tissue was palpated anteriorly. This was presumed to be prostatic tissue. Bilateral inguinal incisions were made. Typical male gross anatomy was noted with external inguinal rings containing well developed cords passing into the labia majora. The "knots" were delivered into the wound and appeared to be normal testes. Biopsy bilaterally revealed normal adult testicular tissue. The left testis was removed for study. The right one was placed in the abdominal cavity, the cord being sutured to the parietal peritoneum and the testis left hanging free. The right indirect inguinal hernia was repaired after the technic of Bassini, and all incisions closed.

PATHOLOGY REPORT

Tissue from normal appearing testicles.

Gross Appearance: The left testis measures 5x3 cm. and is accompanied by what appears to be a normal epididymis and coverings. On gross section, the appearance is that of normal gland tissue.

A block is taken from the midportion and upper pole that appears to be epididymis.

The biopsy taken from the right testis, which has the same gross appearance as the left, is a wedge, 1x.5 cm., all of which is embedded in paraffin.

Microscopical Sections: Sections from Block A show numerous well developed seminiferous tubules, which show some differentiation of the cells, but no actual mature sperm are seen in the lumen. The interstitial cells are prominent and large, with a very bright-staining pink cytoplasm.

Sectoins from Block B show fibrous stroma, in which there are many slightly convoluted tubular structures lined

by tall columnar epithelium. At one edge, there is also some testicular tissue.

Sections from Block C show seminiferous tubules, which are not nearly as cellular as those from the left. Many are partially atrophic and there is also interstitial fibrosis, but here again, the interstitial cells are prominent.

Pathological Diagnosis

Testes with epididymis on left.

Remarks

The right testis is much more atrophic than the left which appears as though it may have been capable of producing normal sperm.

There is nothing even suggestive of ovarian tissue.

The immediate postoperative period was passed uneventfully. Dilatation of the urogenital sinus was begun on January 15, 1951, beginning with the small end of a centrifuge tube.

At the present time the introitus admits a large test tube without difficulty. The depth increased by $\frac{1}{2}$ inch within two weeks; but this progress has slowed considerably since that time.

There has been no change in body configuration and the breasts remain the same. There have been no menopausal symptoms and no gain in weight. The patient's psychological status remains unchanged and she merely states that she is happy to be relieved of the unsightly masses.

She is cooperating well with dilatations and is hoping that the urogenital sinus may reach vaginal proportions, so she may be married in the future.

SUMMARY

1. A typical case of male pseudohermaphroditism is reported.

2. A history is obtained revealing eleven similar cases in the same family covering three generations.

3. The question of heredity as a factor in hermaphroditism is proposed.

4. Efforts are being made to contact all of the individuals so that a more thorough and comprehensive report can be given in a later paper.

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THE MANAGEMENT OF AN UNUSUAL CASE OF ANURIA

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The management of the anuric patient has long been a challenge to the medical profession. This paper is concerned with the acute, non-obstructive anuric patient and not with chronic renal insufficiency secondary to long standing renal disease as would be present in "Bright's" disease or in polycystic kidneys.

The management of her acute anuric patient is based upon the concept that this condition is a self-limited and reversible condition. The kidneys have a tremendous recuperative power and when given the opportunity of mere survival and not endangered by excessive therapeutic efforts will produce spontaneous diuresis in eight to fourteen days. Management is thus directed simply toward maintenance of normal water and electrolyte levels and adequate nutrition of the body. No attempt is made to flood the body with fluids in an effort to stimulate diuresis. This therapeutic effort was once the greatest cause of death in this condition. Nor is it absolutely necessary to resort to expensive artificial kidneys and lavage of various body cavities. This conservative type of management can be carried on under conditions which do

not always provided the facilities for the determination of expensive blood chemistries or the equipment and manpower necessary for the maintenance of various dialyzing procedures.

The following is a list of the more common conditions which produce acute anuria and which are amenable to this concept of conservative therapy.

1. Sulfonamide intoxication.
2. Poisoning: Bichloride of Mercury, Carbon Tetrachloride, etc.
3. Prolonged shock.
4. Toxemias of pregnancy or abortion.
5. Crush syndrome (massive muscle trauma).
6. Burns.
7. Excessive vomiting or dehydration.
8. Intravascular Hemolysis: Transfusion reactions.
9. Heat Stroke.
10. "Reflex Anuria".

Management is based on the following principles:

Prompt recognition of impending renal failure: The urinary output of patients who have ingested poisons, who have been in prolonged shock or who have experienced any of the above conditions should be watched very closely. If the urinary output should fall below 600 cc. per 24 hours impending anuria should be suspected.

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Read before the Medical Association of Georgia in annual session, Augusta, April 18, 1951.

Careful history and physical examination: Pre-existing renal disease should always be ruled out if possible. As in the case presented in this paper the presence or absence of bilateral ureteral calculi had to be determined. The presence of unsuspected polycystic renal disease in a postoperative patient who suddenly became anuric would be important to know in predicting prognosis.

Maintenance of normal water balance, electrolyte balance and nutrition: In the anuric phase enough water is given only to replace that which is lost in respiration, perspiration and in the feces. This is approximately 1000 cc. per day but will vary slightly with sweating in hot weather or in febrile episodes. The amount of fluid lost by vomiting or in diarrhea should be determined and replaced in kind in addition to the basic 1000 cc. amount.

Electrolyte replacement in this phase is minimal. Should acidosis occur in the presence of severe vomiting replacement may be made with sodium bicarbonate by mouth or by the intravenous route. A marked loss of chlorides usually occurs at the onset of diuresis. This is most easily replaced by intravenous normal saline. If possible the amount of chlorides to be replaced should be determined by the serum chloride level. Scribner has recently described a simple, inexpensive and accurate bedside method for this determination. This is necessary because some anuric conditions do not lose as much chloride as others at this time. Sulfonamide intoxication is the best example of this fact as pointed out by Thorn. In the absence of abdominal distention these patients may be fed by mouth or by indwelling gastric tube. Otherwise they are maintained by intravenous fluids. A caloric intake of 2000-2500 calories per day is desired. This is to be made up principally of carbohydrates and fats with a minimal amount of proteins. Supplementary vitamin therapy is given. Under no conditions should the anuric patient be given enough fluid intravenously or otherwise to precipitate pulmonary edema. This concept of flooding the body with fluids in an effort to induce diuresis has produced the death of many anuric patients who otherwise would have survived.

CASE HISTORY

H. B., Grady Memorial Hospital, No. 347185, admitted November 10, 1950, and discharged January 19, 1951. This was the first GMH admission of this 50 year old, colored, male carpenter who was admitted because of severe left flank pain of three days duration. He had been experiencing recurrent attacks of mild, left flank pain for one year, but these had not been incapacitating until three days prior to admission. Past history was non-contributory. Diligent investigation eliminated the possibility of

recent ingestion of poisoned whiskey, mercurials or large amounts of sulfadiazine.

Physical examination revealed an ill, middle aged, Negro male who had a moderate degree of mental confusion. B.P. 110/70; P. 96; R. 20; Temp. 99.6 F. His heart and lungs were normal. His abdomen revealed no palpable liver or spleen. Peristalsis was hypoactive. There was no referred or rebound tenderness. The left flank had moderate muscle guarding and marked tenderness but no mass could be palpated. Rectal examination was normal. The extremities were normal.

Intravenous urograms revealed no function bilaterally. There were several small opacities present in the region of the left lower renal pole and one large opacity in the region of the left ureteropelvic junction. In spite of 1500 cc. of intravenous fluids the patient did not void and did not complain of bladder fullness. Attempts at catheterization revealed an impassable urethral stricture. A suprapubic cystostomy was performed under procaine spinal anesthesia with an anesthetic level up to the sixth thoracic segment. The bladder contained only 30 cc. of murky urine. Examination of this urine revealed many white blood cells per high power field, negative for sugar, negative for sulfadiazine crystals and a one plus albumin. Anuria of the reflex type was suspected at this time, but blockage of the right ureter by a small calculus had to be ruled out. Injection of 5 cc. of indigo carmine intravenously revealed no excretion in 20 minutes. Number 5 Fr. ureteral catheters were passed up both ureters via the cystostomy opening. Obstruction was met on the left at 21 cm. There was no obstruction on the right. No urine was obtained from either catheter. Retrograde pyelograms were made. These films showed complete obstruction of the left ureter by a large calculus in the upper third of the ureter. The right ureter was normal and the right kidney had a normal calyceal outline.

The diagnosis of acute reflex anuria was then made.

A regimen of treatment was started based on the conservative concept of treatment of acute anuria; i.e., restriction of fluids, replacement of lost electrolytes and preservation of general nutrition. Early in the treatment it was found that 10 to 15 per cent dextrose in distilled water thrombosed his veins and 5 per cent dextrose in distilled water had to be substituted. Also on the oral intake of liquids marked abdominal distention occurred and feedings by mouth had to be discontinued. He had to be maintained on intravenous fluids until his 10th hospital day at which time he began to tolerate gastric tube feedings. It was not until the tube feedings were begun that an adequate caloric intake could be maintained.

The hospital course was progressively downhill. He became comatose and irrational and his blood urea nitrogen rose to 189 milligrams per cent on the 7th hospital day. At that time a left nephrostomy was performed under 1 per cent procaine local infiltration. At operation a large hydronephrotic kidney was found. The fluid in the kidney was cultured and was returned as "no growth". Repeated blood cultures taken during the first week also were reported as "no growth". He was on aureomycin therapy when cultures were taken.

With a nephrostomy tube in his left kidney and a suprapubic tube recording the output of his right kidney he became an excellent subject for the study of individual renal function. Indigo carmine injection into the nephrostomy tube did not appear in the bladder. It was then assumed there was no leakage of urine around the left ureteral calculus into the bladder. Following the nephrostomy the left kidney began to produce urine. During the next four days it averaged approximately 100 cc. per day. Specific gravity of this urine was 1.010 and contained four grams of chloride per liter. The right kidney slowly began to produce increasing volumes of urine so that by the 14th hospital day its output was 1000 cc. per day. On this day the blood urea nitrogen was 210 mg. per cent, the serum chloride was 115 milliequivalents per liter and his carbon dioxide combining power was 31 volumes per cent. From the 14th hospital day to the 23rd hospital day his blood urea nitrogen dropped from 210 mg. per cent to 27 mg. per cent. He became conscious and oriented and was able to take a regular diet by mouth. It is interesting to note that as the urinary output of the right kidney increased the urinary output of the left kidney decreased. By the 30th hospital day the left kidney was producing only 20 cc. per day and by the 50th hospital day it had ceased to function altogether. He was discharged on his 70th hospital day with his suprapubic tube out, his urethral stricture dilated to 24 Fr. and his nephrostomy tube in place.

His general condition had improved sufficiently in two months to allow the removal of his non-functioning left kidney. The blood urea nitrogen was 10 mg. per cent. In his anuric phase its highest level had been 227 mg. per cent. Phenolsulfonphthalein excretion was 55 per cent in two hours and his other blood chemistries were within normal limits. He recovered from his nephrectomy uneventfully and is now at home alive and well.

DISCUSSION

Reflex anuria secondary to unilateral ureteral obstruction by a calculus is relatively uncommon though not rare. Lattimer in 1945 reported four cases occurring in thirty-three cases of acute non-obstructive anuria. The mechanism of the

anuria in these cases is unknown. McGowan has postulated a reflex constriction of the renal arterioles. Wolf has stated that the extreme pain produced by the ureteral obstruction reduces the renal blood flow and that anuria results. He is not specific about the exact mechanism involved. Hipsley of Australia is of the opinion that all cases of anuria in association with a ureteral calculus are due to the undiagnosed presence of a calculus in the opposite ureter.

Whatever the mechanism may be of this type of anuria the possibility of its occurrence in each case of unilateral ureteral obstruction should be recognized. This form of anuria follows the course of a lower nephron nephrosis and is amenable to the conservative concept of the treatment of acute anuria. In retrospect the immediate removal of the ureteral calculus in this case might have reduced the severity of the course.

SUMMARY

A plan of treatment of acute non-obstructive anuria is outlined. The most common conditions in which this type of anuria occurs are listed. A case of "reflex anuria" secondary to unilateral blockage by a calculus is presented.

"Reflex anuria" is discussed briefly.

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Watch the Money of a Select Group of Tax Payers Disappear: Five hundred thirty-five million dollars for civil defense, \$335 million for 24 new VA hospitals with 16,000 beds even though many VA institutions are not open today because of lack of physicians to staff them, and \$200,000 for Mr. Ewing's new hospital program for the aged. If my figures are correct there goes another billion dollars without including anything for military activities or defense purposes. Does anyone wish to know the address of their Congressional Representatives and Senators?

The Ewing Hospital Plan for Persons Over 65. With the support of the President, Mr. Ewing has officially proposed a program of free hospitalization for groups of persons now carried by Social Security: (1) All persons over 65 and their dependents, (2) widows under 65 with dependent children, and (3) all survivors eligible for Social Security benefits. Sixty days free hospitalization would be allowed each year.

Medical care is excluded, but drugs, appliances, x-ray and laboratory costs are carried. Such chronic diseases as tuberculosis and mental conditions are not included except when they become acute. It is estimated that 7 million persons would be eligible at a probable cost of \$200 million, which seems to be an extremely conservative figure.

MODERN TREATMENT OF URINARY INFECTIONS

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The advent during recent years of new and more powerful antibiotics has led to changes in the management of patients with urinary infections. Since these new drugs often readily relieve symptoms such as urinary frequency, pain and fever, the very great importance of proper investigation to determine the cause of the infection, should again be emphasized. Furthermore, since sensitivity tests have shown that the newer antiseptics vary in their effectiveness against different organisms it is desirable that probable effectiveness of a drug be determined before prescribing expensive medicines to the patient. Scientific use of such sensitivity tests will save the patient time and money, as well as render the treatment more satisfactory for the doctor. The value of sensitivity tests is by no means confined to treatment of urinary infections. These tests are useful for general surgeons, chest surgeons, plastic surgeons, ORL surgeons, internists, dermatologists, obstetricians, gynecologists. In fact in almost any field of medicine or surgery today, sensitivity tests have been found to be an important aid in treatment of infections.

The purpose of this paper is to again call to your attention the need for proper investigation and determination of the source of infection in patients with pus in the urine. Also we wish to present a simplified method of sensitivity determination that is inexpensive and requires a relatively short time for completion.

The main cause for urinary infection is *stasis*. Whenever stasis is present in any part of the urinary tract, infection is sure to result. Stasis means slowing down of the normal flow, and may be found in any part of the genitourinary tract from a narrow meatus to the ureteropelvic junction or even into the calices. Any point of obstruction usually produces stasis and infection. Other causes of infections in the urinary tract are stones, foreign bodies, malformations in the genitourinary tract and focal infection in distant parts of the body. It is not difficult to see that failure to make proper investigation and correction of obstructions and other abnormalities will lead to failures, recurrences, and greater damage to renal tissue.

The advent of the new drugs has not changed this maxim in urology. They only serve to emphasize the importance of early investigation and proper treatment for patients with urinary infection, because more can be accomplished and more permanent relief from infection can be expected by proper treatment than formerly.

To briefly call your attention to the obstructions, stones and malformations often encountered in patients with urinary infection, a few of the more common conditions will be illustrated (Figs. 1, 2, 3 and 4).

Selection of the proper drug or antibiotic to eradicate the infection is becoming more and more important. Before the advent of the new antibiotics the so-called urinary antiseptics consisted mainly of hexamethylene amine or urotropin, the azo such as pyridium and serenun and a few other impotent or puny drugs. Almost none of these drugs are used today. Control of the pH of the urine has been attempted as a means of rendering conditions unfavorable for bacterial growth. Control of the pH is still regarded as an important part of modern urinary antiseptics.



Fig. 1. Multiple stones in the bladder.

The various sulfa compounds were hailed as miracle drugs but it was soon evident that although many infections were controlled a great many more were not helped by these drugs. Also reactions and toxic manifestations were reported in numerous instances. Penicillin, streptomycin, dihydrostreptomycin, aureomycin, terramycin and chloromycetin, all have been rapidly brought forth as deadly germ killers. Each drug or antibiotic was expected to be the answer to our prayers for a perfect urinary antiseptic. None has proved to be so.

The cost to the patient of these new drugs has been high. This high cost is one of the reasons why cultures and tests of the sensitivity of the organisms to the various antibiotics avail-



Fig. 2. Infected hydronephrosis with kidney practically destroyed.

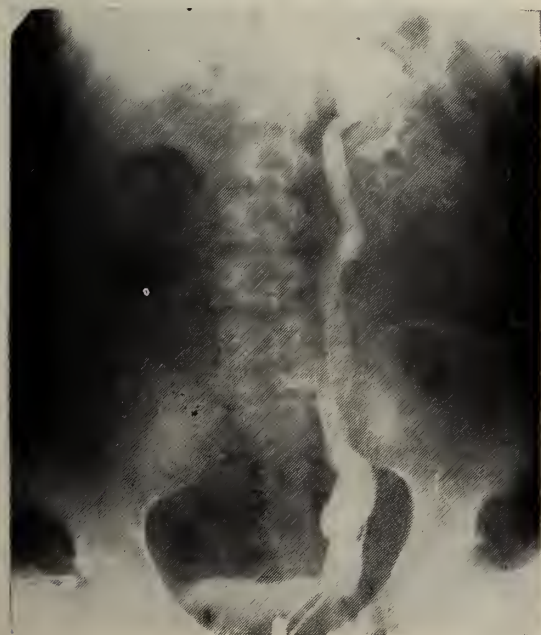


Fig. 3. Double kidney and ureter with dilated ureter and pelvis from upper half.

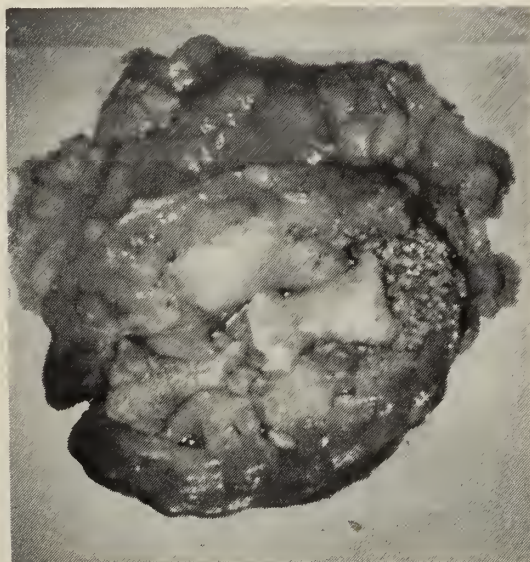


Fig. 4. Pyelonephritis with multiple stag-horn stones causing destruction of the kidney and necessitating nephrectomy.

CULTURES OF 597 URINE SPECIMENS

<i>E. Coli</i>	126	.211
<i>A. aerogenes</i>	124	.208
<i>Staph.</i>	122	.204
<i>Pyocyanus</i>	78	.13
<i>Alc. fecalis</i>	53	.10
<i>P. Vulgaris</i>	43	.075
<i>Strep.</i>	39	.063
<i>Freundi</i>	4	
<i>Friedlander's Bacillus</i>	3	
<i>Yeast</i>	2	
<i>Subtilis</i>	1	
<i>Typhosa</i>	1	
<i>Prodigiosum</i>	1	.02

Fig. 5. Table of cultures made on 597 urine specimens.

be secured by adequate dosage of whatever drug is employed.

Urine cultures have been made on large numbers of infected urines (Fig. 5). By sensitivity tests it is possible to test the drug against the particular organism and to select the most effective drug to give the patient. The clinical results have in almost all instances followed closely the results of these sensitivity tests.

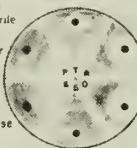
A simple but effective sensitivity test is known as the disc method, first done about two or three years ago by Bondi. The disc method has been found to be relatively inexpensive, rapid, simple and practical. This method as is now recommended, consists of planting the urine or material to be tested in six separate areas on a blood agar plate. The separations

able have become so important. Another reason why it is important to do sensitivity tests is because many different strains of organisms vary in their sensitivity to a particular drug. It has been shown that some organisms become resistant, especially after inadequate dosage of the drug or antibiotic. It is, therefore, also important that satisfactory tissue concentration

DISC METHOD OF ANTIBIOTIC SENSITIVITY TESTS

Cut plate into 6 wedges with loop. Streak each wedge with desired material or organism using sterile cotton swab.

If specimen is cloudy urine or pus-drainage, wedges may be streaked direct from specimen. Place prepared disc of each antibiotic to be tested on streaked wedge (midway at base of wedge). Incubate overnight or 48 hours and read zones of inhibition, using diameter of zone as gauge of effectiveness.



Diameter of inhibition zone
 0-5mm - no response
 5-15mm - minimal response
 15-20mm - fair response
 20-25mm - good response
 25mm + - excellent response

Concentration of discs

Penicillin 10 U
 Streptomycin 10 U
 Gentrisin 50 mcgm
 Aureomycin 50 mcgm
 Terramycin 50 mcgm
 Chloromycetin 50 mcgm

Fig. 6. Showing disc methods of multiple sensitivity tests and making determinations with six antibiotics at one time.

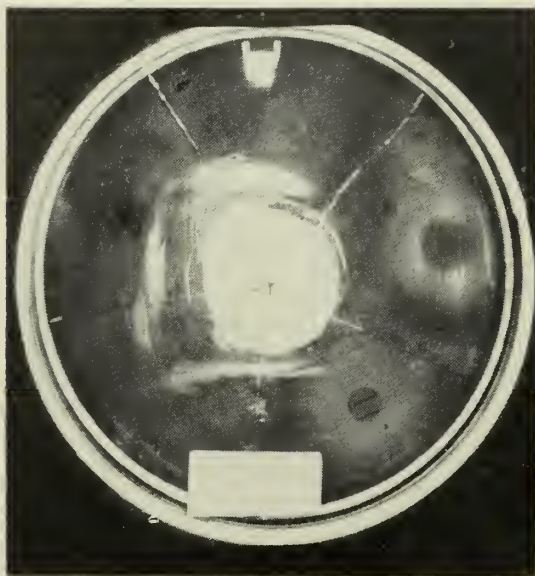


Fig. 7. Photograph of culture plate 24 hours after implantations of medicated discs. Note wide zone of inhibition around aureomycin and chloromycetin.

are made by cutting the agar after cooling into six pie-shaped wedges with a platinum loop. After the material is planted a small disc of blotting or filter paper which has previously been impregnated with the drug or antibiotic is placed on each area. Six different drugs are thereby tested at one time on the same plate. Plates planted for testing are usually ready for reading the reaction after overnight incubation at 37° F. centigrade. The zone of growth inhibition observed surrounding the disc indicates the susceptibility of the organism to the drug. The wider the zone of no growth the more sensitive the organism is to the medicine. The reactions have been graded according to the diameter of the zone of growth inhibition (Fig. 6). When two or more drugs are seen to be effective against the organism they are sometimes given simultaneously. Identification of the organism may be carried out but when using the disc

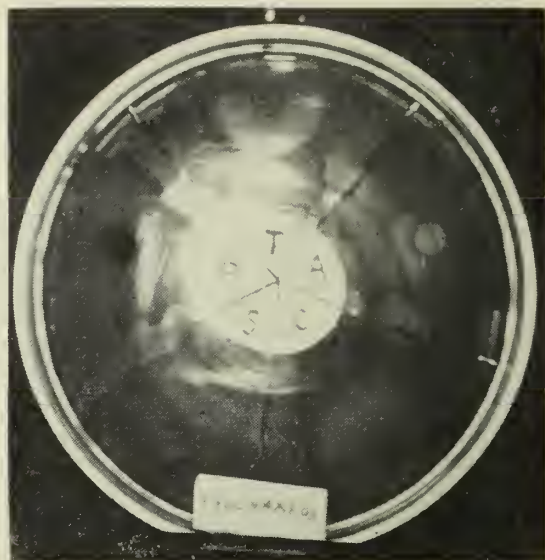


Fig. 8. Photograph of culture plate showing wide zone of inhibition around chloromycetin and terramycin.

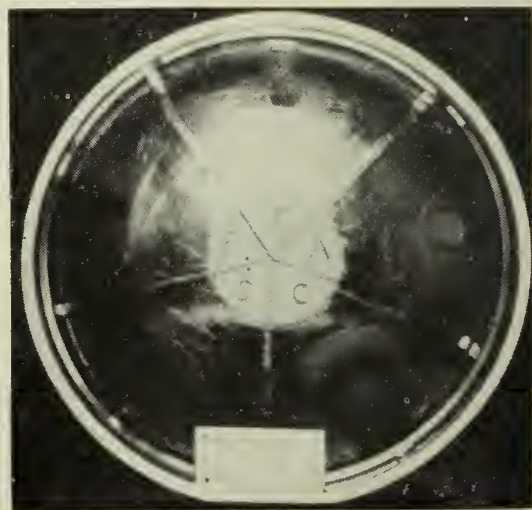


Fig. 9. Photograph of culture plate showing wide zone of inhibition around chloromycetin and penicillin.

method, treatment need not await this identification (Figs. 7, 8 and 9).

SUMMARY

Modern treatment of urinary infections consists of eradication of foci of infection, relief of obstruction, correction of abnormalities causing stasis, removal of stones or foreign bodies. A proper examination should be carried out when patients are seen with pus in the urine. Urinary antiseptics should be given on a basis of probable effectiveness as determined by sensitivity tests of the infected urine against the various drugs and antibiotics commonly used and available today. The disc method is a simple,

practical and relatively inexpensive way to determine whether a drug inhibits an infecting organism. Tests have shown results that are satisfactory as an indicator as to which drug or drugs to employ in treating the patient. The usefulness of this determination is not limited to the field of urology but is applicable to practically all fields of medicine.

57 Forsyth St., N. W., Atlanta, Ga.

ABSTRACT OF DISCUSSION

DR. ROBERT W. McALLISTER, Macon: Dr. Freeman has presented a very interesting case of male pseudohermaphroditism, particularly so because of its familial aspects.

Male pseudohermaphroditism and perineal hypospadias are essentially one and the same. It appears that Dr. Freeman's patient was a male with hypogonadism, perineal hypospadias, bifid scrotum or labia majora with fairly normal testes.

Dr. Freeman chose to let this patient continue her life as a male and I feel that his choice of treatment was proper especially after seeing his beautiful Kodachrome slides. It is obvious that this patient is receiving estrogens from her adrenals or the testicle.

Plastic surgery and the administration chorionic gonadotrophins and androgens could probably have given this patient a reasonable facsimile of male external genitalia. Had this been done, it is highly doubtful that this patient could have adjusted to the life of a male after 18 years of being a female. However, several times each year the lay press gives before and after photographs of sex changes from evening dress to baseball uniform.

Dr. Freeman's patient is apparently happy and has no psychic or sociological adjustment to make.

Had this patient had prepubertal treatment I feel that male external genitalia should have been reconstructed.

This brings up the question of whether the 8 year old sibling should be treated as a male. I think not, for psychological reasons.

I shall look forward to further reports from Dr. Freeman concerning this unusual family.

Drs. Banks and Hill have presented an excellent concise treatment of the subject of acute non-obstructive anurias. The basic plan of treatment submitted, namely: "Restriction of fluids, replacement of lost electrolytes and preservation of general nutrition," alone; has and will save many lives. Only in the last three or four years have we learned to quit drowning patients during the anuric stage and to replace lost electrolytes during the period of diuresis. The regimen with the use of effective dialyzing apparatus in the future may make lower nephron nephrosis much less of a problem. Peritoneal and gastric lavage have been of no value in my experience.

Drs. Banks and Hill's case of reflex anuria is most unusual and their therapeutic approach was indeed rational. Immediate removal of the left urethral stone may have conceivably reduced the severity of the course. However, atrophy and loss of function of the left kidney probably would have taken place as it did while on nephrostomy drainage, because of probably irreparable damage to its blood supply, from perirenal inflammatory reaction or from pressure from the sacular mass.

Reflex anuria of the type presented does not often occur. The type usually seen by the urologic surgeon, follows transurethral resection of the prostate gland even when isotonic irrigating media are used.

Dr. McDonald has presented a very practical paper and I wish to join him in emphasizing the importance of ruling out anomalies, stones and obstructions when treating urinary tract infections, and further that antibiotics shall not be given in a haphazard hit or miss manner. We cannot expect to permanently cure a urinary tract infection where static urine is present, nor can we expect

results from antibiotics and chemotherapeutic agents unless we do urine cultures and drug sensitivity tests. Three dollars spent on sensitivity tests may save the patient many times that amount if the wrong expensive antibiotic is administered. Repeated infections should always demand a complete urologic survey. All of these papers have been good.

Abstract of Discussion of papers "Chloromycetin Treatment of Typhoid Fever", Drs. D. F. Mullins, Jr., and Wm. H. Bonner; "The Basic Concepts of Allergic Disease", Ellison Richards Cook, III, continued from pages 253-258 of THE JOURNAL, June 1951.—Ed.

DR. T. F. SELLERS, Atlanta: There is plenty in the literature to support the experience of Dr. Bonner in the treatment of typhoid fever with chloromycetin. Unfortunately, there is also plenty in the literature to show how ineffective chloromycetin is in the treatment of the typhoid carrier state.

After all, typhoid fever is strictly a human infection, and is perpetuated by the carrier; so far, no medication whatsoever has been effective in sterilizing the typhoid carrier. The only procedure having any degree of success is cholecystectomy.

We have on the list of the State Health Department 150 known typhoid carriers, and it would be most wonderful indeed if chloromycetin or some of the antibiotics could help in the sterilization of those carriers. We certainly would rapidly expedite the control of the disease.

In regard to Dr. Cook's paper, there is one phase that we have come in contact with in regard to the administration of antirahic vaccine. Occasionally we have specific types of reactions following antirahic vaccine, the most serious one being the condition known as treatment paralysis. This has nothing to do with rahies or with the presence of rahies virus.

The sensitization with a specific brain tissue or nerve tissue protein has been accomplished with normal tissue experimentally; so there is no question today, I think, but that this phenomenon of treatment paralysis is a specific neurotissue sensitization phenomenon.

We have had seven cases in our experience at the State Health Department, four of which were fatal, five of which occurred following retreatment.

Consider the fact that antirahic treatment is administered in the form of repeated injections for from 12 to 21 days, and it is not surprising that this phenomenon should develop, particularly since it has been produced with even more and greater frequency experimentally in animals with normal tissue.

The only treatment I can suggest is prevention—that is, in avoidance of the use of antirahic treatment except when it is definitely indicated.

DR. C. RAYMOND ARP, Atlanta: Dr. Cook's conception of doctors' attitude toward allergy is correct. Many doctors do not believe in allergic reactions and others do not want to be bothered by taking care of them and may actually feel antagonistic toward allergic patients.

By reminding us that a reaction similar to the urticarial wheal occurs on membranes of the nose in hay fever and on the mucous membranes of the bronchioles in bronchial asthma, Dr. Cook has succeeded in making us at once feel familiar with the pathology and pathologic physiology of these processes.

I would like to emphasize that the simple wheal stage does not last long. In the bronchioles widespread edema of the mucous membranes rather soon becomes one of the most important factors in the production of symptoms of bronchial asthma, due to narrowing of the lumina. The narrowing is accentuated by muscle spasm in the walls of the bronchioles and as the result of thick, tenacious mucus partially filling or even completely blocking the lumen of the bronchioles or larger bronchi. We have seen asthmatic patients get better as they were

able to cough out mucus casts of the bronchial tree. There has been much discussion as to which is more important, bronchiolar spasm or edema of the mucous membranes, in producing wheezing and dyspnea. I, personally, feel that it depends to some extent on the severity of the status asthmaticus and the length of time that it has been present. I feel that oftentimes we see immediate, dramatic improvement on the administration of aminophylline and the prompt response must indicate that in that particular patient, bronchiolar spasm is the more important factor. In other patients the response is slower and in these, edema of the mucous membranes is probably the more important factor.

We believe that the iodides are used much less frequently than they should be. Orally, potassium iodide is certainly the best. If it cannot be tolerated by the patient, the administration of sodium iodide intravenously in doses of 2 grams, once or twice daily, will be effective.

We have had one serious reaction to the intravenous use of aminophylline. I hesitate to give aminophylline too rapidly, but rather use a 25 or 26 gauge needle to administer a dose of 3¾ grains in a 10 cc. syringe. Patients will occasionally get a feeling of tightness in the chest, pain in the chest or increased dyspnea, and this is a signal to stop the injection.

We have had success with the prolonged intravenous drip of aminophylline, using 1 gram to the 1000 cc. of intravenous fluid. Most patients with status asthmaticus are benefited by the intravenous fluid since dehydration develops from excessive perspiration, lack of fluid intake due to nausea, anorexia and mechanical difficulty of drinking. With dehydration there is thickening of the mucus which plugs the bronchioles and bronchi.

Walzer and his associates in Brooklyn, have shown that polyp formation is reversible in some instances. Polyp formation is more frequent in patients who have both infection in the sinuses and allergy in the nose and sinuses, and if the polyps must be removed because of mechanical obstruction, treatment of both infection and the allergic condition is indicated. It is often difficult at times to tell the difference between hay fever, common cold, chronic sinus disease and the effect of lues on the nose. We must remember that all of these must be differentiated. The finding of eosinophils in the nasal secretion is positive evidence of allergy but if they are not found it does not mean that the condition cannot be allergic.

Our experience with ACTH and cortisone in allergic disturbances is the same as that of Dr. Cook. They are valuable to bring acute symptoms under control, but appear to do nothing for the patient's basic allergic state. I believe that this is true in most diseases for which ACTH and cortisone are used, with the possible exception of rheumatic fever, where there is some preliminary indication that valvular damage may be avoided. In a patient who has an isolated attack of urticaria such as those seen after penicillin reactions, controlling the acute attack with these drugs and gradually reducing the dose and finally discontinuing them, may be the simplest way to take care of that attack.

Many allergists feel that food allergy is not important in hay fever and asthma in adults, but some hold the opposite view, such as Randolph in Chicago, and Rinkel in Kansas City. I, personally, feel that it is not too unusual to find food allergies playing a fairly important part in these conditions in adults. It is more common of course, in children. House dust is the greatest offender that we find so far as inhalants are concerned. In so-called intrinsic asthma, proof that bacterial allergy plays the greatest part, is lacking. In many of these cases we have simply not worked out the patient completely enough to determine his sensitivity. In a lecture last year Dr. Harvey Black made the statement that he had seen only one case that he thought was intrinsic asthma, in some thirty years of practice.

In allergy the patient must be considered as an individual and his disease, as the only one of its kind.

DR. HAL DAVISON, Atlanta: While it is wrong to diagnose anything as an allergy that is due to other pathology, it certainly must be true that it is just as wrong to diagnose a condition due to other pathology when it is actually due to allergy.

One other point I want to mention is the fact that a Spanish physician by the name of Farreron-Coe showed that prolonged administration of adrenalin at times increases the histamine instead of decreasing it. He was the man who started the use of the injection of benadryl a long time ago with adrenalin when you have to use it for a long time.

Another point about the use of adrenalin that we should remember is that many of these so-called adrenalin reactions following the use of adrenalin in oil is due not to the effect of the sensitivity to adrenalin, but to the fact that the syringe had a drop of water in it. The adrenalin is in the form of a powder suspended in the oil, and the syringe with which this is administered must be absolutely dry. One small drop of water the size of a pin head will dissolve enough of the adrenalin to cause serious results.

PHYSICIANS LICENSED IN GEORGIA

DATE OF LICENSES—June 7, 1951: George Bunch Adams, Albany; James Leon Alexander, Augusta; Joseph Harrison Brannen, Atlanta; Simone Brocato, Columbus; Elza Vance Bullock, Augusta; Herbert Walker Burton, Atlanta; Paul Willard Carlisle, Decatur; Parish Browman Cleveland, Toccoa; Vincent John Cirincione, Pembroke; Peter James Cline, Atlanta; Lee Roy Minor Conn, Columbus; Evelyn Vail Coonrad, Warm Springs; George Penn Dillard, Jr., Rome; Martin Donelson, Jr., Atlanta; Ernest Goodall Edwards, Jr., Savannah; Marvin McCall Gibson, Douglas; Edgar Dunkley Grady, Chamblee; James Frank Hooker, Atlanta; Robert Todd Hyde, Doraville; George Aubrey Johnston, Macon; Leo Francis Klenk, LaGrange; Theodora Finney Lippitt, Savannah; Charles Gillespie Luther, Jr., Augusta; Leonard Thomas Maholick, Savannah; Louis O. J. Manganiello, Augusta; Earl Atkinson Mayo, Jr., Richland; David Smyth McKee, Atlanta; Francis Meredith Parks, Milledgeville; Arthur Anthony Smith, Atlanta; Ralph Erhart Wenzel, Columbus, and Kathleen Ruth Wickman, Chamblee.

DATE OF LICENSES—June 29, 1951: Elizabeth Knowles Adams, Emory University; Edwin Whitaker Allen, Jr., Milledgeville; William Reeves Anderson, Atlanta; Earnest Calvin Atkins, Jr., Atlanta; James Thomas Atkins, Atlanta; Henry Wright Bailey, Augusta; Heinz Bauer, Decatur; Robert Chadwick Behrens, Decatur; William Radford Birdsong, Gordon; William Walton Bledsoe, Jr., Augusta; Joseph Thomas Brock, Jr., Dothan, Ala.; Roy Crawford Brock, Decatur; Thomas Dearborn Burleigh, Jr., Atlanta; Jack Henry Burnett, Jr., Emory University; Perry Greene Busbee, Jr., Vienna; Joseph Lawton Caldwell, Jr., Augusta; James Edgar Cantrell, Augusta; Frederick Albertin Carpenter, Emory University; Howard Christy Chandler, Jacksonville, Fla.; Joseph Harvey Chandler, Emory University; Robie Thomas Childers, Atlanta; Donald Murray Christoffers, Keystone Heights, Fla.; Spurgeon William Clark, Jr., Waycross; Robert Powell Coggins, Marietta; Sheldon Bradley Cohen, Augusta; William Edwin Coleman, Graymont; David Hal Conner, Mt. Vernon; Harry Jackson Crider, Jr., Atlanta; Francis Maier Cronin, Gainesville; Claude Murphy Cupp, Emory University; Jack Dalton Daniel, Charlottesville, Va.; William Wright Daniel, Atlanta; Lee Hosch Darby, Vidalia; Ernest Evan Denney, Amarillo, Texas; James Clyde Dismuke, Jr., Augusta; Richard Albert Dodelin, Decatur; Charles Hinton Drake, Collins; Lige Moultrie DuBose, Chamblee; George Clovis Duncan, Carrollton; John Alfred Alexander Duncan, Augusta; Reese Clarence Eberhardt, Maysville; Wilson Taft Edenfield, Lyons; James Patrick Evans, Athens; George Marion Faile, Jr., Greenville, S. C.; John Duncan Farris, Emory University; John Henry Folsom, Jr., Winter Park, Fla.

(To be continued in *The Journal*)

THE USE OF ACTH AND CORTISONE IN THE TREATMENT OF ANOREXIA NERVOSA

ROBERT B. GREENBLATT, M.D.; WM. E. BARFIELD, M.D., and SARAH L. CLARK, M.S., Augusta

The adolescent or young adult patient with weakness, anemia, and loss of gonadal function, along with adrenal and thyroid insufficiency and progressive cachexia, offers a diagnostic and therapeutic problem.

True pituitary cachexia (Simmonds' disease), although rare, is often confused with anorexia nervosa. The polyglandular hypofunction of Simmonds' disease results from organic pathology involving the anterior pituitary gland, and interfering with its stimulation of thyroid, adrenal and gonadal functions. Simmonds' disease, therefore, is primarily a panhypopituitarism resulting in arrest in sexual development, amenorrhea or hypogonadal function, hypothyroidism, and adrenal cortical insufficiency. The latter is responsible for hypoglycemic attacks, increased tolerance to carbohydrates (as observed in the glucose tolerance test), insulin sensitivity (as seen in the insulin tolerance test), early increase in total eosinophil count with poor resistance to allergenic or physiologic stress, as well as the complete or almost total loss of axillary, pubic and body hair. The eosinophil count in advanced cases of panhypopituitarism may be decreased due to depression of the bone marrow. The low urinary content of adrenal glucocorticoids and 17-ketosteroids are also indicative of the secondary adrenal cortical insufficiency. Primary pituitary cachexia may be insidious in onset and progressive, as seen in destructive lesions such as chromophobe adenoma, or may be rather sudden following parturition or severe infection (Sheehan's disease).

The similarity between anorexia nervosa and Simmonds' disease frequently offers difficulty in differential diagnosis. In both there is progressive loss of weight and gynecic function, low B.M.R., hypotension, asthenia and bradycardia. Anorexia nervosa occurs most frequently in adolescent or young adult females, and secondary amenorrhea is often associated with regression of the vaginal cytology to a state of extreme estrogen deficiency. Anorexia nervosa is primarily a psychiatric disorder with onset following some emotional crisis, and the resulting polyglandular endocrine deficiency is secondary, perhaps, to a hypothalamico-pituitary "block", or to starvation. Secondary hypopituitarism is also seen in wasting diseases such as advanced tuberculosis, interference with small

bowel absorption, and other severe chronic infections. It appears that the pituitary gland under these circumstances sacrifices those metabolic functions not essential to life so that the available essential amino acids may be utilized in production of the pituitary adrenocorticotropins which are essential for life.

The restless energy and stubborn, uncooperative attitude are usually prominent in the patient with anorexia nervosa. Many of them seem to enjoy the attention and turmoil which result from their progressive debility. The urinary 17-ketosteroids are normal or slightly elevated. In further contrast to Simmonds' disease, patients with anorexia nervosa do not lose their axillary or pubic hair. Instead, the presence of an additional growth of fine, "lanugo-like" hair over the abdomen and trunk, and often on the face and arms, has been such a constant observation at this clinic that we believe it a pathognomonic sign.

Although the fundamental treatment requires the greatest skill of a competent psychiatrist, endocrine therapy has much to offer in support of the metabolic deficiencies resulting from polyglandular insufficiency. Substitution therapy at the level of the target glands with estrogens, androgens, desoxycorticosterone, and thyroid extract have proved of value in maintaining the patient in a state of improved metabolic balance until psychiatric readjustment is accomplished. Since adrenocorticotrophic hormone has become available, it was felt that more complete replacement of adrenal cortical function by stimulation of the gland itself might prove a beneficial adjunct to present therapy, particularly because of the euphoria, well-being, and increased appetite that usually accompanies therapy with adrenocorticotrophic hormone or cortisone. It was also felt that administration of cortisone might be a valuable addition to adrenal cortical replacement therapy, which had not been available heretofore.

The purpose of this paper is to present our experiences with adrenocorticotrophic hormone and with cortisone in the treatment of five patients with anorexia nervosa.

METHODS

The diagnosis was established in each of the five cases by careful medical history (including psychiatric consultation), physical examination, and laboratory survey. In addition to routine hematologic and urinary studies, other observations included the eosinophil response to adrenalin and to adrenocorticotrophic hormone (Thorn test), glucose tolerance test, insu-

From the Department of Endocrinology, Medical College of Georgia, Augusta.

Read before the Medical Association of Georgia in annual session, Augusta, April 19, 1951.

lin tolerance test, x-ray of sella turcica and wrists (for bone age), urinary assay for 24-hour excretion of adrenal glucocorticoids, 17-ketosteroids, creatin, and creatinine, evaluation of exfoliative vaginal cytology, and, indicated in one case, a gastrointestinal series. The general appearance of emaciation and weakness was a constant observation. Axillary and pubic hair growth were normal in all cases, and the presence of additional growth of fine hair over the trunk, abdomen, face, and extremities was striking in all five patients.

Adrenocorticotrophic hormone and cortisone were administered as separate courses of therapy, with one exception in which the cortisone was given for 7 days immediately following a 9-day course of therapy with ACTH (Case 4). Three patients received both ACTH and cortisone as separate courses of therapy, and two patients received only cortisone. The total dose of ACTH varied from 250 mg. to 350 mg. over a period of 9 to 10 days. Eight courses of therapy with cortisone were administered with a total dosage varying some 425 mg. in 5 days to 1000 mg. in 10 days and in one case 1500 mg. was administered orally over a period of 30 days.

RESULTS

The observation of beneficial response to therapy was not constant. One extremely uncooperative patient derived no apparent benefit from ACTH therapy for 9 days, nor from cortisone the following 7 days (Case 4). In two patients cortisone therapy resulted in unquestionable improvement in appetite and attitude, and a permanent gain in weight of 15 pounds over a period of one and three months respectively (Case 2, 3). Two patients were definitely benefited by addition of ACTH therapy (Case 1 and 5). One of these (Case 1) reported extreme depression during therapy with cortisone one month after ACTH therapy, and oral cortisone therapy 4 months later resulted in this same untoward reaction. On the other hand, one patient whose primary symptom was spastic abdominal pain with diarrhea after ingestion of food was completely relieved of these symptoms for three weeks after cortisone therapy (Case 2) and gained 15 pounds during this time. Two subsequent courses of therapy with cortisone resulted in the same excellent relief of symptoms. One patient (Case 5) who had derived fair temporary rehabilitation for 16 months from steroid therapy (estrogen, androgen, and desoxycorticosterone acetate) and thyroid extract was given 25 mg. ACTH daily for ten days when admitted to the hospital in a bedridden, weak, and apparently moribund condition. At the end of the 10-day course of therapy the patient was much stronger, eating well, ambulatory, and presented a complete reversal of her hopeless attitude. Progress has continued for one year now, on therapy with estrogens, androgens, thyroid extract, and

vitamin supplements. This patient has gained 21 pounds (from 63 to 84 lbs.), and has had four apparently normal menstrual periods. Subjective and objective evaluation of therapy in this case revealed that the course of ACTH gave greater immediate improvement with increased feeling of well-being, strength, weight gain, and hope for recovery; and that steroid therapy following the ACTH resulted in more permanent progressive improvement than did previous steroid therapy alone.

UNTOWARD REACTIONS TO THERAPY

In all five patients there appeared mild to moderate generalized edema during therapy with either ACTH or cortisone in the dosage used. This was satisfactorily controlled in every instance by administration of Potassium Chloride in doses of one gram three times daily.

One patient experienced extreme mental depression during each of two courses of therapy with cortisone—one by the intramuscular route, and the other orally.

Insomnia and nocturnal restlessness were reported by two of the three patients who received ACTH.

CASE REPORTS

Case 1. M. R., w. f., aged 20 (x-ray technician). Amenorrhea 9 mos., weight loss 30 pounds in 5 mos., anorexia, vomiting. Wt. 84, emaciation, normal sexual hair—new growth of fine hair over body. B. P. 90/70, BMR Minus 24, Vaginal smear: atrophic.

Aug. 1950 Hospitalized 10 days:

ACTH 50 mg. daily x 2	Stronger, improved attitude, gained 6 lbs., Eosinophils decreased from 500 to 100.
40 mg. daily x 1	
20 mg. daily x 7	

Sept. 1950 Hospitalized 10 days:

Cortisone 100 mg. daily x 10	Urinary glucocorticoids increased. Severe mental depression, no subjective improvement.
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Jan. 1951:

Oral cortisone 50 mg. daily x 30	Depressed—same as with injections. Lost 11 lbs. (79 lbs.). Edema controlled with KCl 1 Gm. t.i.d.
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Continued therapy with estrogen, androgen, thyroid gr. $\frac{1}{4}$ and multivitamins. Later voluntarily submitted to 8 treatments of Brief Stimulus Electrotherapy, with apparently satisfactory results. This was followed by weight gain of 25 pounds in about two months.

Case 2. J. F., w. f., aged 19. Amenorrhea 3 yrs. following removal of tonsils. Weight loss 102 to 76 lbs. Spastic colitis with diarrhea—3 years. Maculopapular dermatosis—1 year. Anorexia because of abdominal spasm and diarrhea following ingestion of food. Atrophic vaginal smear. Keppler water test normal. BMR plus 3, serum cholesterol 140. Gastrointestinal series normal.

March 1950 Hospitalized 18 days:

2000 Calorie diet, Regular Insulin	No improvement, no gain in weight.
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10 U. t.i.d. before meals.

April 1950:

Methyltestosterone 50 mg. t.i.d. for 21 days.	Weight gain 11 pounds (76 to 87½ lbs.). Four months later weighed 98 pounds.
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Sept. 1950:

Cortisone 100 mg. daily x 7	Appetite excellent, no diarrhea for 3 weeks following therapy, no change in atrophic vaginal smear.
75 mg. daily x 1	
50 mg. daily x 1	
25 mg. daily x 1	

Nov. 1950:

Oral Cortisone 25 mg. daily x 30, Testosterone propionate 25 mg. per week.	Improved appetite and well-being; no diarrhea.
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Jan. 1951:

Oral Cortisone 25 mg. daily x 30, Testosterone propionate 25 mg. per week.	Same as Nov. and dermatitis improved.
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Case 3. B. M., w. f., aged 35. Voluntary starvation diet since age 15 because of fear of obesity. Forced vomiting every meal except breakfast for 10 years. Energetic, but weak. Vaginal smear—atrophic. Sexual hair normal. Additional growth of fine hair on face and arms. Keppler water excretion test—borderline.

Nov. 1950 Hospitalized 30 days:

Cortisone 100 mg. t.i.d. x 1 day	Definite improvement in appetite and attitude. Weight gain 15 lbs. (68 to 83 lbs.). Edema controlled with oral KCl.
100 mg. b.i.d. x 1 day	
100 mg. daily x 1	
75 mg. daily x 1	
50 mg. daily x 3	
25 mg. daily x 4	

Dismissed after subcutaneous implantation of testosterone propionate pellets (2 x 75 mg.), multivitamin supplement, thyroid extract, and constant psychiatric attention. Six weeks later weighed 94 pounds.

Case 4. M.A., w. f., 19 (only child). Always underweight; onset of illness indefinite, acute for a few months, with inability to eat or drink anything other than soft carbonated drinks; always "high-strung" and "nervous". Menses regular. Normal axillary and pubic hair plus growth of fine hair over face and body.

Aug. 1950 Hospitalized 18 days:

ACTH 40 mg. daily x 8 days	No improvement, uncooperative, refused to eat, refused tube-feeding.
30 mg. daily x 1 day then	

Cortisone

100 mg. daily x 7 days

Case 5. Mrs. H. M., w. f., 23. Vomiting after ingestion of food, with weight loss from 112 to 60 pounds in two years; amenorrhea 8 mos. Seen by many physicians with no response to liver, iron, vitamins, and attempts at dietary therapy. Atrophic vaginal smear. Normal sexual hair plus "lanugo-like" hair on face and trunk.

Dec. 1948: Steroid therapy—

Diethylstilbestrol 0.1 mg. twice daily.

Testosterone propionate (pellet implantation 2 x 75 mg.) Thyroid extract gr. $\frac{1}{4}$ daily, and multivitamin supplement. For three months on this regime the patient felt stronger, but did not return for re-evaluation as advised.

Dec. 1949 hospitalized 6 weeks: Weak, vomiting, weight 63 pounds.

2000 calorie diet for 6 weeks (gavage first 10 days) resulted in some increased strength, but no weight gain. Steroid therapy: Before dismissal from hospital patient was given thyroid extract gr. $\frac{1}{2}$ daily, oral estrogen therapy, vitamin supplement, and pellet implantation of testosterone propionate (2 x 75 mg) and desoxycorticosterone acetate (1 x 75 mg.).

April 1950 hospitalized 13 days: During the four month interval the patient became hedridden, weak, apparently moribund—unable to turn over in bed without assistance. Weight 63 pounds, B. P. 90/50, circulating eosinophils—

none (bone marrow exhaustion?), vaginal smear—atrophic ("castrate").

Therapy consisted of tube-feeding of 5000 calories daily for 6 days, then high caloric low residue diet with small feedings every hour. Then ACTH 25 mg. per day was administered intramuscularly for 10 days. By the end of this time the patient was out of bed, walking around, and there was dramatic subjective improvement. Weight on dismissal was 64½ pounds. Oral estrogen and androgen therapy, vitamins, and thyroid gr. $\frac{1}{2}$ daily were continued.

Sept. 1950. In the 5 months after ACTH therapy the patient had experienced a complete change of attitude, weight gain to 80 pounds, and developed a good appetite.

Cortisone

100 mg. daily for 3 days

75 mg. daily for 1 day

50 mg. daily for 1 day

Urinary glucocorticoids and

17-ketosteroids were in-

creased during this ther-

apy.

April 1951: At last examination, one year after the short course of ACTH therapy, this patient weighed 84 pounds, remains happy and has a good appetite, and had experienced four apparently normal episodes of spontaneous menstrual bleeding. It appeared that ACTH gave more immediate improvement, with greater increase in feeling of well-being, strength, weight gain, and hope for recovery; and that steroid and supportive therapy following ACTH therapy offered more permanent progressive improvement than did previous steroid therapy alone.

CONCLUSIONS

1. Five patients with anorexia nervosa were treated with ACTH or cortisone, or both in separate courses of therapy, in varying dosage.

2. Statistically valid conclusions were not attempted from observations of response to therapy in these five cases.

3. One of the five patients treated derived no apparent benefit from therapy with either ACTH or cortisone. Two of the three patients who received ACTH responded immediately with marked increase in feeling of well-being, strength, weight gain, and remarkable reversal of attitude. One patient who had improved as a result of ACTH therapy derived no benefit from two subsequent courses of therapy with cortisone, however two other patients who received cortisone alone were greatly benefited by this therapy.

4. Untoward reactions to therapy:

a. Although edema was observed in all five cases during therapy with either cortisone or ACTH, it was satisfactorily controlled by oral administration of potassium chloride.

b. Mental depression was experienced by one patient during each of two courses of therapy with cortisone.

c. Insomnia and nocturnal restlessness were reported by two of three patients who received ACTH.

5. Adrenocorticotrophic hormone and cortisone are valuable adjuncts to current endocrine replacement therapy for maintenance of metabolic balance in the patient with anorexia nervosa until satisfactory psychiatric readjustment is accomplished.

THE JOURNAL

OF THE
MEDICAL ASSOCIATION OF GEORGIA
Established 1911

DAVID HENRY POER, M.D., Editor
875 West Peachtree Street, N. E.
Atlanta, Georgia

JULY, 1951

YOUR NEW SECRETARY

With pleasure I introduce to you Mr. Sid Wrightsman, Jr. who took over the duties of Executive Secretary of the Association on July 16. In addition, Mr. Wrightsman will be in charge of the Public Relations Department, and will have the able assistance of Miss Viola Berry, Mrs. John Malthie, and Mr. W. D. Gazaway in carrying on the work of the Association.

Mr. Wrightsman comes to us with excellent recommendations from the Arkansas Medical Society where he has held the position of Executive Secretary during the past three years. Apparently similar conditions exist in that State to those found in Georgia and it is felt that his experiences there can serve of tremendous value in improving medical organization work and public relations in our State.

A veteran of the Air Force in the past war, he spent much of his service at Hunter Air Base in Savannah and other air bases in the South. He then returned to the University of Texas and completed his degree in Journalism in 1947. He had a short experience with the *Galveston Tribune* as reporter, and then did six months work as Publicity Director for the Malaria Control Board in Arkansas. He is married to the daughter of a physician, Dr. A. R. Chambers, a general practitioner of Iola, Kansas.

Thus my own short but interesting tour of duty as Executive Secretary of the Association comes to a much needed end, and I point with modest pride to the accomplishment of part of my platform of April 13. Many members have realized the great need for a full time experienced secretary to carry on the increasing duties of that office which becomes more complicated each day. With the added responsibilities of Public Relations activities, a trained staff of specialists soon becomes an absolute requirement.

It is my plan to carry on the duties of Editor of *THE JOURNAL*, and I hope to announce the approval of Council of an able Editorial Board in the August number. I will also continue to serve as Treasurer of the Association because of the requirements of our present Constitution and By-Laws. In addition I will give Mr. Wrightsman all the assistance that I can and request



SID WRIGHTSMAN, JR.

that all members do the same, particularly the Officers of the County and District Societies.

All communications should be directed to Mr. Wrightsman.

D. H. P.

ARE SURGEONS GUILTY?

No business or profession known to man, including the ministry, can present a totally clean front to the public, and contrary-wise the public with which these groups deal is made up of the good and the bad. Since all professions, and particularly the medical groups, are supposedly made up of men of the highest types and presumably above reproach, it has always been difficult for the profession as a whole to police itself and do effective house cleaning of known offensive practices. The very nature of the practice of medicine, containing as it does the application of the arts as well as the sciences, makes it difficult for any one physician to point his finger at another and tell him that he is not doing the right thing.

Now that the medical profession has been projected so strongly into the public eye, many peo-

ple including well-wishers of physicians, have brought forth suggestions that the dirty spots be cleaned or at least aired to the public. One of these spots unfortunately concerns the work of surgeons, who, paradoxically are often cast in the role of the supreme hero by the patient and family and at the same time may be doing the greatest amount of harm to the individual. In spite of the fact that many checks have been thrown up in an attempt to control both the selection of patients for surgery and the type of operation performed, it is still possible for the unscrupulous operator to carry out unnecessary and actually harmful procedures. Add to that the equally unscrupulous general practitioner or diagnostician who refers unsuspecting patients to such individuals and the odor of the situation becomes even more offensive.

Conscientious surgeons have spoken out openly against such practices many times and in fact the world's largest surgical organization, the American College of Surgeons, which was founded in 1913, requires a pledge against fee splitting as a basic requirement. In addition it has carried on a program of extensive hospital inspections over the entire country to see that the records show that operations are indicated in the first place, and done at the proper time, and with the proper regard for conservatism.

The most recent appeal to surgeons themselves, who after all are the final judges of their own actions, was made in a forceful chairman's address to the Surgical Section of the A.M.A. by Dr. I. S. Ravdin, Professor of Surgery at the University of Pennsylvania School of Medicine, Philadelphia. Pointedly calling attention to many of the dirty spots on surgeons' linen he outlined this six-point program for correction:

1. Stop overcharging for operations.
2. Cut out "needless operations" which "cater to the whims of distraught patients" and are "unnecessary because the symptoms are psychosomatic in origin." Ravdin mentioned "the rape of the pelvis," adding that 37 per cent of pelvic operations could be avoided.
3. Halt fee-splitting between surgeons and family doctors. "We shudder when we read about the kickback in industry and the 'five percenters' . . . yet we turn our backs on the same iniquitous practice in surgery."
4. Eliminate "ghost surgery" in which the family doctor employs a surgeon to do the operation. The surgeon has no part in the decisions. "He lurks in the shadows, selling his services, and the patient thinks 'his doctor did the operation'."
5. Stop the "unnecessary consultations" and the forcing on the patient of "a particular group of consultants."
6. Make sure that surgery is performed only by men who are properly trained.

In defense of surgeons it is undoubtedly true that these sins apply only to a small percentage

and by and large patients are now receiving better surgical care than at any time in history. The long periods of training in an increasing number of medical centers, the elevation of the surgery as a separate specialty by the various specialty boards requiring the passage of difficult examinations for certification, the constant activity of accrediting organizations have been successful in raising the plane of surgery to its highest level.

THE HOSPITAL SITUATION IN GEORGIA

Recently in the daily press of the State, a feature item appeared giving the story of the Hill-Burton program in Georgia since it was inaugurated in 1947, with details concerning the expenditure of over \$30,000,000 for new hospital and health centers. This information was released from the offices of the State Department of Health whose officials have had this program under control since its inception. Also in this number of *THE JOURNAL*, there appears an article by the Assistant Director of the Hospital Division giving similar information of the progress that has been made to date.

Georgians rightly point with pride to the 39 new hospitals, 6 additions to existing hospitals, and 41 Health Centers that have been completed, or are in the process of construction or have been approved when funds are available. These will add over 2,000 badly needed beds to the total in the State, which was said to be 6,758 short in a survey revised this year. It might be that this figure presupposed the willingness of a community to pay the taxes necessary to support the prescribed quota of beds determined by Washington desk authorities to be the ideal for the nation, plus the financial ability of the to-be-patients to pay the cost of hospitalization known to be high and steadily increasing.

Citizens of our State are also proud to learn that Georgia ranks so high in the number of projects completed and planned in comparison with other Southern States and the nation as a whole, and this is no doubt due to the splendid work done in this division by the first Director, Mr. J. E. Ransom up to the time of his tragic death, and now by Dr. R. C. Williams, under the direction of Dr. T. F. Sellers. This active group has devoted much time and study to the hospital situation in Georgia both in regard to the size and location of new projects, and to the administrative experiences of hospitals that have been in operation before and after the beginning of the Hill-Burton program. Local Hospital Authorities would do well to study carefully the figures concerning the cost of operation of a hospital that are available to them. These actual experiences of others could be of tremendous value in helping to determine the minimum num-

ber of beds that would provide the most badly needed services in their community, and that the taxpayers would be willing to support. In some instances, communities have explored the feasibility of combining with nearby adjoining counties or considered the possibility of having a Health Center only to lessen the financial burden, and at the same time improve medical care in their area.

Controversial points naturally have arisen and to answer some of the questions that have come up a preliminary study of a cross-section of small hospitals (13 to 50 beds) has provided valuable information. Of prime importance is the determination of the minimum number of beds that a hospital should contain to be operated efficiently from a professional standpoint and economically in providing non-medical requirements. It is well known that hospitals can be either too large or too small, and the Hospital Division has determined that 25 beds is the least number that a community should ever plan for unless unusual circumstances exist. If the services of specialists are considered necessary then it is probable that 100 beds would be required.

Viewing this part of the problem from a different angle, small communities have been advised that if they expect to attract new and well trained physicians to rural and small town areas, they must provide hospital facilities similar to those in which students and interns now receive their education. In Georgia it has been found to be true in that the number of physicians usually increases when a new hospital is constructed and in no instance did the number of physicians actually decrease except by normal attrition.

In the hospitals with 13 and 50 beds that were studied, the rate of occupancy did not exceed 66 per cent in 1950 and was noted to be as low as 29 per cent (average 42 per cent) in some. This figure will cause some concern to planners of new units because it would seem to indicate that more beds were built than were needed. A deficit gap is anticipated normally when a hospital is opened in a community that previously has had none, but one hospital studied had been in operation for 10 years with 56 per cent occupancy and another 16 years with only 66 per cent. The smallest unit with 13 beds had been in operation 8 years, and had an occupancy rate of 35 per cent.

Naturally the construction and cost of operation of hospitals under those circumstances would be a severe burden to small communities, and this is reflected in the deficits which ranged from \$1500.00 to \$13,700 in 1950. This averaged \$176.00 per bed in Hill-Burton hospitals, and some small degree of comfort to the taxpayers in those areas can be had in comparing this with average deficit in other Southern States (\$386.00). For small hospitals in some states

this figure has risen to \$546.00. One answer seems to lie in larger units, built and operated by several communities jointly, in which the cost of maintenance per bed is less, and professional services improved by attracting more physicians with special training. Another partial solution would be a marked increase in the charges to the pay patients but it is likely that those are already about as high as the traffic will bear.

It would seem that the responsible authorities of the 25 or more communities in Georgia that are known to be planning or considering the feasibility of constructing new hospitals in the near future, would pause and give serious consideration to the results of these progress studies while it is still possible to tailor their plans more accurately to the needs and financial abilities of their constituents. Certainly many of them can reduce the number of beds to be constructed providing the basic facilities to allow additions, or consider the possibility of a community clinic having only a few holding beds for obstetrical, accident and minor surgical patients. The latter plan has proven to be adequate and much less expensive to operate in Mississippi and in North Carolina. Or the feasibility of combining with adjoining counties to provide a larger and more efficient hospital bears very serious thought and should be repeated.

Naturally the officials in the Hospital Division of the State Board of Health want to give the taxpaying citizens of Georgia the number and type of hospitals that they desire. However, they are run in a position to counsel and give helpful advice based on the experiences of hospitals now in operation for years. Rather than continue to increase the total number of units, consideration can be given to the improvement of existing hospitals especially those that act as regional units with staffs of qualified specialists available for consultation.

Likewise some thought and planning must be given to hospitals for separate conditions such as mental, tuberculosis, social diseases and children's diseases such as poliomyelitis and cerebral palsy. With relief on the pressure for more general hospitals attention must be given to the needs of the State for these important services.

DR. W. L. CHAMPION

In college days the Annual and Year Books were dedicated to the most popular and beloved members of the faculty. If that custom still prevailed we would proudly dedicate this number of THE JOURNAL to the Dean of urologists and close friend of all physicians in Georgia, William Leon Champion.

ATLANTIC CITY SESSION OF A.M.A.

In Atlantic City June 11-14, 1951, the American Medical Association held its 100th annual session with a registration of 12,229 physicians. Georgia was represented by 77 physicians. The Woman's Auxiliary registered over 1,500 physicians' wives.

At this meeting 358 papers covering every phase of medicine were presented. The 19 Scientific Sections displayed 297 scientific exhibits. Two motion picture theaters running daily showed a total of 37 films. There were 17 colored television demonstrations. For the first time in the history of television, a normal delivery was presented. All these activities required the services of 2,000 physicians.

Twenty-three wire recordings of different programs were made to be broadcast over the "Voice of America." Three hundred and fifty technical exhibits were on display; and this is the largest number ever shown at an A.M.A. annual session.

The House of Delegates began its deliberations Monday at 10:00 A. M. and finished Thursday at 3:30 P. M. There are 200 delegates representing every state and territory in the United States. Two additional delegates, representing the newly-formed Student American Medical Association, were seated for the first time. One hundred and ninety-nine delegates answered the roll calls.

All deliberations and proceedings of the House of Delegates will appear in the JOURNAL, but some of the more important actions deserve emphasis at this time:

1. Approved a resolution supporting federal financial aid to medical schools for construction only, based on the Hill-Burton Hospital Construction Act.

2. Authorized expansion of the A. M. A. Physician Placement Service through which many communities may obtain assistance in securing the service of a physician.

3. Requested a wider dissemination of factual information pertaining to the practice of medicine.

4. Adopted a resolution urging a thorough investigation of activities aimed at indoctrination of students in grammar schools, high schools and colleges with the insidious and destructive tenets of the welfare state.

5. Adopted a resolution requiring the A. M. A. to prepare specific replies to arguments referring to shortage of physicians and other medical care topics and to acquaint the public with plans of the A. M. A. for better medical care through press and radio.

6. Deferred a resolution to abolish A. M. A. Fellowship dues.

7. Referred to the Board of Trustees a resolution on hospital accreditation, with several recommendations. A joint commission has been set

up, consisting of twelve physicians and six laymen and the A. M. A. has six representatives. The final report from the Board of Trustees is expected at the next session.

The Board of Trustees announced that a special lay advisory committee of prominent representatives of labor, industry, education, the bar and the clergy will be formed to advise in matters of medical care and to present the viewpoint of the general public.

Dr. Allen O. Whipple, director of surgery, Memorial Hospital, New York City, received the annual Distinguished Service Award.

Dr. John W. Cline, San Francisco, Associate Clinical Professor of Surgery, Stanford University, was installed as President of the A. M. A., succeeding Dr. Elmer L. Henderson, of Louisville, Ky. The oath of office and his inaugural address were presented in a nationwide broadcast.

Dr. Louis H. Bauer, Hempstead, N. Y., Chairman of the Board of Trustees of the A. M. A. and a nationally known cardiologist, was the unanimous choice for President-Elect.

Dr. Oscar B. Hunter, Washington, D. C., radiologist, was elected vice-president.

Whitaker and Baxter have been retained for 1952, on a part-time basis, to continue as head of the A. M. A. National Educational Campaign.

The American Medical Golf Association had 264 golfers on hand for the 36th annual meeting. Dr. Frank Lahey, of Boston, is the new president.

The American Physicians Art Association has a membership of 4,000. Over 700 entries in 18 different media were on display at this session.

The American Medical Educational Foundation to help the nation's hard-pressed medical schools has united its resources with the National Fund for Medical Education recently formed in New York City and headed by former President of the United States, Herbert Hoover. More than \$650,000 has been raised by the A. M. A. Mr. Hoover has set \$5,000,000 as the goal for 1951. Every physician is urged to contribute to this fund to show that the financial problems of the medical schools can be solved by voluntary sources. A contribution of \$10,000 from the Woman's Auxiliary to this fund was announced. The California Medical Association voted \$100,000, South Carolina Medical Association voted \$10,000, and New York State is undertaking to raise \$250,000 for this fund.

Three Gold Medal Awards, two Silver and two Bronze Medals were announced. Two of these were given for contributions to developments on surgery of the heart. One of the Silver Medals went to workers from the Bowman Gray School of Medicine of Wake Forest College at Winston-Salem for a study of Phospholipid Synthesis using Radiophosphorus.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

THE EXPANSION OF HOSPITAL AND CLINICAL FACILITIES IN GEORGIA

JAMES M. SITTON, Assistant Director, Hospital Services, Georgia Department of Public Health, Atlanta

Of particular interest to the physicians of Georgia is the State Hospital Program which has as its objective the extension and improvement of hospital and clinical facilities. The ultimate objective, of course, is to assist the physicians in providing a high standard of medical care.

The State Hospital Plan is the basic document which summarizes the annual State-wide inventory of existing hospital facilities, and reflects the recommendations of the State Board of Health pertaining to the relative need, size and location of such facilities throughout the State. The primary purpose of the State Hospital Plan is the systematic and inter-related development of such additional hospital facilities as may be required to provide adequately for the people of Georgia.

Annually (usually in April), or more frequently if necessary, the State Hospital Plan is reviewed, taking into consideration changes or trends in population, hospitals constructed during the past year, local conditions relative to hospital planning, and such other factors

as the State Board of Health may deem advisable.

To date in Georgia emphasis has been placed on the construction of general hospitals and public health centers. The Federal Hospital Survey and Construction Act as amended gives the State Board of Health authority to establish annually the percentage of Federal participation in individual projects. The percentages in effect at the present time are 55 per cent of the project cost from Federal funds, 25 per cent from State funds and 20 per cent provided by the sponsor.

The following table shows the amount of Federal and State funds made available for grants to projects in Georgia since the beginning of the Hospital Facilities Construction Program.

Fiscal Year	Federal Funds	State Funds
1947-48	\$2,976,228.00	\$ none
1948-49	2,791,307.00	3,000,000.00
1949-50	5,248,356.00	3,000,000.00
1950-51	2,609,914.00	3,000,000.00
TOTAL	\$13,625,805.00	\$9,000,000.00

The three tables which follow show the projects which have been completed, those now under construction, and those approved for construction.

PROJECTS COMPLETED

County	City	Name of Hospital	Number of Beds	Cost
Bibb	Macon	Macon City Hospital (Alterations)	0	\$ 156,445.37
Bibb	Macon	Macon City Hospital (Remodel 5th floor)	28	57,858.66
Calhoun	Arlington	Arlington City Hospital	16	158,900.00
Carroll	Carrollton	Tanner Memorial Hospital	37	528,000.00
Clarke	Athens	Athens General Hospital (Addition)	11	552,900.00
Cobb	Marietta	Kennestone Hospital	105	1,226,321.95
Cook	Adel	The Memorial Hospital	27	193,800.00
Elbert	Elberton	Elberton-Elbert County Hospital	47	780,276.00
Franklin	Royston	Cobb Memorial Hospital	23	213,460.32
Greene	Greensboro	Minnie G. Boswell Memorial Hospital	28	401,250.00
Heard	Franklin	Heard County Memorial Hospital * (Equip.)	18	17,217.22
Mitchell	Camilla	Mitchell County Hospital	32	268,168.72
Mitchell	Camilla	Mitchell County Hospital—Nurses Home	—	42,903.00
Murray	Chatsworth	Murray County Memorial Hospital * (Equip.)	19	41,000.00
Muscogee	Columbus	St. Francis Hospital	154	1,910,566.68
Spalding	Griffin	Griffin-Spalding County Hospital	96	1,321,491.00
Stewart	Richland	Stewart-Webster Hospital	24	255,536.38
Terrell	Dawson	Terrell County Hospital	28	254,167.50
Troup	LaGrange	City-County Hospital (Addition)	74	504,000.00
Upson	Thomaston	Upson County Hospital	92	1,122,000.00
Worth	Sylvester	Worth County Hospital	28	294,716.03
TOTALS			887	\$10,300,978.83

* (Federal and State aid only in equipping the facility).

PROJECTS NOW UNDER CONSTRUCTION

<i>County</i>	<i>City</i>	<i>Name of Hospital</i>	<i>Number of Beds</i>	<i>Estimated Cost</i>
Appling	Baxley	Appling County Hospital	27	\$ 258,024.90
Barrow	Winder	Barrow County Hospital	40	550,000.00
Burke	Waynesboro	Waynesboro-Burke County Hospital	38	416,069.91
Chattooga	Summerville	Chattooga County Hospital	31	345,000.00
Emanuel	Swainsboro	Emanuel County Hospital	50	591,790.00
Floyd	Rome	Batley State Hospital—Laboratory	—	156,055.00
Floyd	Rome	Batley State Hospital—Nurses Home	—	161,520.00
Fulton	Atlanta	Atlanta Negro Hospital	116	1,717,984.02
Habersham	Demorest	Habersham County Hospital	44	499,545.00
Hall	Gainesville	Hall County Hospital	112	1,608,306.00
Jasper	Monticello	Jasper County Hospital	25	260,000.00
McDuffie	Thomson	McDuffie County Hospital	29	325,500.00
Polk	Cedartown	Polk General (Hospital Addition)	10	69,500.00
Rabun	Clayton	Clayton-Rabun County Hospital	20	237,000.00
Richmond	Augusta	St. Joseph Hospital	110	1,566,000.00
Screven	Sylvania	Screven County Hospital	34	332,000.00
Stephens	Toccoa	Stephens County Hospital	16	405,275.20
Sumter	Americus	Americus-Sumter County Hospital	100	1,320,000.00
Telfair	McRae	McRae-Telfair County Hospital	30	360,000.00
Towns	Hiawassee	Lee M. Happ, Jr. Memorial Hospital	14	173,065.00
TOTALS			846	\$11,352,635.03

PROJECTS APPROVED FOR CONSTRUCTION

<i>County</i>	<i>City</i>	<i>Name of Hospital</i>	<i>Number of Beds</i>	<i>Estimated Cost</i>
Bacon	Alma	Bacon County Hospital	30	\$ 300,000.00
Coffec	Douglas	Coffee County Hospital	60	750,000.00
Laurens	Dublin	Laurens County Hospital	60	800,000.00
Lowndes	Valdosta	Valdosta-Lowndes County Hospital	100	1,300,000.00
Richmond	Augusta	University Hospital (Addition)	10	900,000.00
Sumter	Americus	Americus Colored Hospital ((Alterations)	—	107,000.00
Walker	Fort	Tri-County Hospital		
	Oglethorpe	(Dade-Walker and Catoosa Counties)	100	1,000,000.00
Treutlen	Soperton	Treutlen County Hospital	25	282,000.00
TOTALS			385	\$5,439,000.00

The Georgia Department of Public Health through the Division of Hospital Services endeavors to provide consultation service to hospitals in the State, particularly the newly opened hospitals to aid in every way in the proper functioning of those institutions and to assist them in serving the people of the State.

In addition to the construction of new hospitals or enlargement of existing ones, thirteen public health centers, twenty-five auxiliary health centers, two nurses homes and a laboratory at Batley State Hospital have been approved.

To encourage better physical facilities, the State Board of Health, as provided by the Hospital Regulation Act. No. 623, Georgia Laws 1946, has promulgated rules and regulations for the protection of the health and lives of the inmates and patients in hospitals and has prescribed the kind of facilities which hospitals shall provide to properly care for patients. Two

hundred permits have been issued to hospitals for 1951.

The procurement of qualified professional and technical personnel for the operation of new hospitals being completed and now under construction is the most urgent problem which requires consideration at the present time.

**NEXT ANNUAL SESSION
OF THE
MEDICAL ASSOCIATION OF GEORGIA
ATLANTA BILTMORE HOTEL
ATLANTA, GEORGIA
DATES: May 11, 12, 13, 14, 1952**

ORGANIZATION SECTION

ABSTRACT OF PROCEEDINGS OF THE AUGUSTA SESSION, MINUTES OF THE ANNUAL SESSION OF THE HOUSE OF DELEGATES OF THE MEDICAL ASSOCIATION OF GEORGIA, HELD IN AUGUSTA, APR. 17-20, 1951

(Continued from Page 271)

The actions of the House of Delegates at the Augusta Session are herewith abstracted so that the readers may have this information in digest form. The official proceedings are on file at the Association headquarters and are open to any member who wishes to examine them.—Ed.

HOUSE OF DELEGATES Tuesday Evening, April 17

The second meeting of the House of Delegates convened at 8:30 p.m., Dr. Alpheus Maynard Phillips, president, presiding.

Report of the President of the Woman's Auxiliary, Mrs. L. W. Williams, Savannah.

Published in the Woman's Auxiliary Section of The Journal for June 1951.—Ed.

Report of Committee on Maternal Care, Dr. C. B. Upshaw, Chairman, Atlanta

A meeting of the committee was held in the chairman's office, in January. We were fortunate in having Doctor Hilda Sheriff, of Columbia, South Carolina, who is active on a similar committee for the State of South Carolina meet with us. Most of the time was taken up in an informal discussion as to (1) the best methods of obtaining data from the attending physician in maternal deaths, and (2) how best to make use of this data from an educational standpoint for the profession. Many valuable suggestions were made, and it is believed that there are great possibilities for raising our standards of obstetric care throughout the state by the proper dissemination of knowledge gained through a careful survey of our maternal mortality. It is evident that much time and effort will be required to pursue this study.

In view of the great number of details involved, and since the reports are slow to come in, and so much time is required in such a study, it would seem that the committee for Maternal Mortality should really be appointed for three years. If this is possible under the Constitution, it certainly seems practical.

Report of the Committee on Tuberculosis, Dr. Sam E. Patton, Chairman, Macon

The tuberculosis control program is progressing satisfactorily at the present time. The present needs to improve the program are, (1) increase in x-ray survey programs, (2) more hospital beds for the hopeless case, (3) improvement in the welfare benefits available to tuberculous cases and their families, and (4) more facilities for earlier admission of cases to hospitals for treatment after diagnosis.

Efforts are being made by all agencies interested in tuberculosis, to remedy these phases of the tuberculosis program.

Tuberculosis is on the decrease, but constant awareness of the contacts of young men in foreign lands is necessary, and use of x-rays to determine the exact condition of veteran's lung status is often necessary. The fact that the incidence rate of elderly white men is double what it was in 1926 is most important to note.

Excellent cooperation between all agencies concerned in this problem has continued.

Tuberculosis is decreasing in rate, but there is still a large number of cases and the eradication of the disease is decades off. Adequate welfare set-ups for the tuberculars and their dependents is necessary for continued improvement in control.

It is recommended that the agencies be commended for the work in tuberculosis and that they be encouraged and urged to continue the control program without let up. It is further recommended that the physicians of this state continue their efforts at case finding and treatment along with tuberculosis educational work.

Report of the Committee on Civilian Preparedness, Dr. Edgar M. Dunstan, Chairman, Atlanta

The Chairman represented the Medical Association of Georgia at the semi-annual meeting of the Council on National Emergency Service of the AMA in Chicago, May 6, 1950. The editorial appearing in the June 10, 1950 issue of the J.A.M.A. gives a good summary of what was accomplished at that very important meeting.

Immediately following this meeting, Col. Frank A. Kopf, State Civil Defense Coordinator, was contacted and some of the information was transmitted to him. The chairman of the committee conferred with Dr. T. F. Sellers, who was appointed by the Governor to direct the State Medical and Health Services under Col. Kopf. Assurance was given by Dr. Sellers that there would be adequate representation from organized medicine in the advisory civil defense councils at all levels and this has been carried out consistently.

Our committee has mimeographed a tentative plan for the utilization of the Georgia organized medical personnel in case of major disasters and had this distributed to all county medical societies in the State asking for criticisms, comments and suggestions. The plan is based on the one prepared for the State of Maine by Dr. Steele's committee with slight modifications. A copy of this tentative plan is attached (filed for reference). Suggestions given in the manual on Health Services and Special Weapons Defense will be included.

The State and the Fulton County Civil Defense Committees cooperated in presenting the following educational program for physicians throughout the State at the Academy of Medicine, Atlanta, Sept. 14, 1950.

a. The Status of Civil Preparedness in Georgia, and Remarks on Radiological Safety by Col. Frank A. Kopf, Georgia Civil Defense Coordinator.

b. Motion picture (official W. D. Film): The Tale of Two Cities ((Hiroshima and Nagasaki)).

c. Application of Present Knowledge of Atomic Bomb Possibilities to the City of Atlanta by Dr. Charles E. Dowman, Atlanta.

d. Present Status of Chemical, Biological, and Psychological Warfare by Dr. Joseph S. Skobba, Atlanta.

e. Discussion by Dr. Bernard P. Wolff, Atlanta.

The State and the Fulton County Civil Defense Committees conducted a forum on Civil Defense for the public at the Academy of Medicine, Atlanta, Nov. 3, 1950. Col. Frank A. Kopf, Mr. George Phillips and Dr. Charles E. Dowman were the main speakers and Dr. George Dowling, Dr. Joseph S. Skobba and Dr. Lester M. Petrie also were on the panel to answer questions.

The Georgia Legislature passed the Civil Defense Act in February 1951, and the Governor appointed Major General Ernest Vandiver as Civil Defense Director, and Dr. T. F. Sellers, as Director of the Health Services Division. Dr. Sellers in turn appointed Dr. Lester M. Petrie as Deputy Director of Health

Services and the Chairman of this committee as Assistant Director in charge of the Medical Services. Other members of the committee have been and are being appointed to positions in the administrative set-up which is now being organized.

RECOMMENDATIONS:

1. That a committee of nine members be appointed to continue advising the Health Services Division of the State Civil Defense Administration.
2. That the membership of the committee include at least one member in each Public Health District in the State so as to insure close liaison in the important problems which will arise constantly.
3. That careful attention continue to be given to the appointment of men who are interested in the problems of Special Weapons Defense and who are willing to devote the time to keep themselves abreast of the rapid developments in this field.
4. That The Journal of the Medical Association of Georgia print at an early date a series of three or more articles concerning Civil Defense matters to be prepared by members of this committee.
5. That consideration be given to eventually organizing our State Medical Civil Defense set-up in line with that of the parent AMA Council. In this connection, the record of the duties, membership, and term of office of the parent Council on Emergency Medical Service of the AMA is attached (filed for reference).

Report of Committee on Medical Education and Hospitals, Dr. G. Lombard Kelly, Chairman, Augusta

I have recently attended the annual convention of the Association of American Medical Colleges, along with Dr. Hugh Wood and other representatives of our schools at Lake Placid, New York, and other meetings of that kind. There are factors that might be considered in regard to medical education such as the attempt at the present time to bring about federal subsidization of medical education.

Of the seventy-nine medical schools in this country, seventy-two have gone on record as being in favor of S-337. Personally, I am opposed in principle to the entering of the federal government into this field, and I have written to every member of the Senate Committee and have given them my views, in the hope that the American Medical Association, through its Foundation, would be given an opportunity to carry on this work. The senators replied that they cannot carry this thing on as a sustained effort. I say, give the AMA a chance.

I know that there are medical schools in this country today—endowed schools—that are in very sad straits financially; but I believe financial assistance should be given to those schools which need it most. I do not think state-supported medical schools require this assistance in the same way that endowed schools do.

In regard to the hospital side of the picture, this committee might have taken some action in regard to proposing the new State Hospital on the campus of the Medical College of Georgia. I don't know that it was the function of this committee to take part in the effort to bring about the enactment of legislation to provide the poor people of Georgia with a State hospital. You probably knew we have succeeded in having legislation enacted, and that probably in the fall we will begin construction of a 769-bed State General Hospital on the campus of the Medical College of Georgia. There will be 100 beds set aside in the hospital for cancer teaching and research, fifty beds for tuberculosis, fifty for psychiatry, and the remaining will be general medical and surgical beds.

Report of Committee on Practical Nurse Education and Registration, Dr. John A. Simpson, Chairman, Athens

The need for practical nurses or nurses' aids in the homes to look after chronically ill patients, postopera-

tive and postpartum patients and babies has long been present in Georgia. Now they are also needed in our hospitals and more will be needed with the new hospitals that are being built. The number of graduate nurses available cannot possibly meet our present needs much less the extra beds that are being added. This leaves us without any trained help to assist in the homes.

Realizing a need for this type of help to our patients, a committee has met with the president and the chairman of the committee on Practical Nurse Education of the Georgia Nurses Association and a hospital administrator and makes the following report and recommendation to the Medical Association of Georgia:

We suggest that selected women, white and colored, be taught simple bedside procedure as outlined in a curriculum including baths, limited massages, changing bed linen, giving enemas, taking temperatures, counting pulse, caring for the mother after childbirth, caring for newborn babies, making formulas, a working knowledge of asepsis, a knowledge of diets, and the giving of certain medications on written order of physician only.

The National Association for Practical Nurse Education proposes that a course of from 9 to 12 months be given before a practical nurse can be certified. This includes extended courses in bacteriology, chemistry, sterile technic and dietetics. It has been suggested that this be prolonged to 18 months, but it is the feeling of this committee that a course of 12 months would be sufficient.

The certification of practical nurses is usually done through State Boards of Nurse Examiners in other states.

There are several books published on the teaching of practical nurses, but these, the committee feels, may cover many subjects that should not be taught. We feel that a very inexpensive book covering only subjects needed should be written.

Report of Committee on Insurance, Dr. John W. Turner, Chairman, Atlanta

In May, 1949, your committee reported that a Special Disability Insurance Plan submitted by the Commercial Casualty Insurance Company seemed appropriate for our needs and the House of Delegates adopted the recommendations. The group was officially set up on a statewide basis in April, 1950, and it has proven its value to our membership. To date this company has paid in excess of \$16,000 in claims without a single complaint in claim service. Of the total membership of the Medical Association of Georgia, 608 are carrying this insurance.

Every member of the Association who meets eligibility requirements, namely, that he is under the age of 60 years, and is in the active practice of medicine, has been canvassed by letter and many members, except the members of the Bibb County Medical Society, have been canvassed by personal interview.

It is my understanding that some of our members are buying individual policies in preference to participating in our group contract. This costs the individual member more for equal benefits than he would have to pay by participating in the group plan.

We need as large a participation as can be secured. The premium cost on the Group plan is at least 30 per cent less than the cost of like insurance purchased individually.

All members under 60 years of age are eligible to apply, but the company reserves the right to approve or reject the application. New members in the profession and those in Military or Naval service will be accepted without reservation if application is made within forty days after becoming members or re-engaging in civilian practice.

During the past year your committee has been approached by other companies requesting that their policy be accepted and endorsed by the Medical Associa-

tion of Georgia. The committee has no prejudice against these companies, but believes that we have already in force a policy that is satisfactory.

The committee believes further that to permit another company to enter the field requiring a coverage of 50 per cent of members before activating their policy would tend to dilute the field and possibly jeopardize the insurance now in effect.

After careful consideration, it is the recommendation of the Committee to the House of Delegates that the advantages of the group insurance policy be brought to the attention of the members and that the members be urged to avail themselves of these advantages for their personal benefit as well as for the benefit of their confreres in the association.

Recently the company has increased the benefits obtainable under this policy at no additional cost.

Adjournment.

Third Meeting—Friday Morning, April 20

The final session of the House of Delegates convened at 8:30 a.m., Dr. Phillips, President, presiding.

Report of Reference Committee No. 1,

Dr. George H. Alexander, Forsyth

The minutes of 1950 annual session were approved, and the President's Report including the following recommendations was endorsed:

1. That duties of officers shall be redefined. However, we believe that this will be accomplished in the adoption of a new Constitution.
2. That the Woman's Auxiliary be subsidized to the extent of \$600 yearly.
3. That the Public Relations Department be continued, except that financial control be handled separately.
4. That the President's Page in The Journal be published without censorship.

It also concurred in recommendation by President-Elect W. F. Reavis that more time be allowed essayist on program, and that the Woman's Auxiliary be subsidized to the extent of \$600 yearly. After study of the Secretary-Treasurer's Report we find the Association to be in a healthy condition both physically and financially. Publication of the report of Delegates to the American Medical Association in The Journal was recommended. The report of the Parliamentarian was noted and filed. The report of Reference Committee No. 1 was adopted unanimously.

Report of Reference Committee No. 2,

Dr. T. F. Sellers, Atlanta

Committee on Scientific Work: The function of this committee has been most satisfactorily carried out, and we recommend its acceptance. In addition, we recommend that the time allotted for the presentation of papers be extended from twelve to fifteen minutes, and discussions from two to three minutes.

Committee on Public Policy and Legislation: This report denotes considerable activity especially during the 1951 session of the State Legislature, not only in promoting legislation of direct value to the interests of the Association but also in successfully opposing unfavorable legislation. Since this was a recessed session of the legislature, to be reconvened in January 1952, we recommend that this committee, subject to the wishes of the President, be continued for another annual term.

We recommend the acceptance of the report of the committee, including the suggestion that the retiring President each year call to the attention of the members such legislation as he deems necessary for our progress and for the protection of the public. We especially approve the committee's suggestion that the Association's attorney make a study of the laws that are obsolete and out of keeping with the present status of our organization and the public interest.

Committee on Abner Wellborn Calhoun Lecture-ship: The selection of Dr. Irving S. Wright of New York to speak on "Neurovascular Syndromes of the

Shoulder Girdle, Including Hyperabduction Syndrome," was most excellent, and we recommend that Dr. Paullin be congratulated for procuring this splendid speaker.

Committee on Medical History: The report of this committee is most interesting and informative. It is obvious that Dr. J. C. Weaver is devoting much of his time and effort, without recompense, to the accumulation of valuable historical data and to laying plans for further expansion of his studies. We heartily recommend the acceptance of this report. Incidentally, this committee won first prize.

Committee on Revision of the Constitution and By-laws: In the limited time available we have given much thought and time to the study of this report. We have had the benefit of consultation with the Chairman of the Committee, Dr. Allen H. Bunce, and also with a number of members of the Association who sought us out to make comments and recommendations.

We highly commend the Committee for accomplishing so much in such a difficult assignment, and we are recommending the adoption of the report with the following changes:

That Article II, Purpose of the Association (page 1 of the report, read: "The purposes of the Association shall be to advance the science of medicine; to promote the interests and uphold the honor of the profession of medicine; to acquire, utilize and disseminate information relative to all diseases and degenerative processes affecting mankind, to the end that the people of Georgia may have the most adequate medical care possible; to promote public health, and to foster cordial relations between the members of the medical profession and the general public."

That Article IV of the Constitution, Section 2, read:

"Whereas, the members of the Association are the members of the component county medical societies..."

That Chapter V of the By-laws, Section 4, page 20 of the report be changed. In the seventh line, substituting the words "President-elect" for the word "President".

That Chapter VIII, Section 7 of the By-laws, page 34 of the report be changed. On the third line from the bottom of page 34, substituting the word "four" for the word "five".

The report was adopted as amended.

Report of Reference Committee No. 3,

Dr. W. L. Pomeroy, Waycross

Committee on Maternal Mortality: We commend the early groundwork done by this Committee, approve heartily of its objectives, and recommend that this Committee be continued and that Dr. George Niles, Jr., of Atlanta, be added to this Committee.

Committee on Practical Nurse Education and Registration: This is an important Committee, and we commend the group for the progress made at this early date. The practical nurse is here to stay, and we believe that regulation, education and control of this group of people is necessary. We recommend that this Committee be continued and started to work without delay.

Committee on Group Insurance: We commend the work of this Committee in making available to the membership group disability insurance at a low cost. Furthermore, we second the recommendation of the Committee that the advantages of group insurance be brought to the attention of the membership in order that more members may avail themselves of the benefits to be derived therefrom, both from a personal standpoint and to the benefit of their confreres in the Association. (It was recommended that this committee be continued by an amendment).

Committee on Civilian Preparedness: We recommend that this Committee of nine members be continued, and its recommendations be adopted, and sufficient publicity be given in The Journal of the Medical

Association of Georgia to keep the membership abreast of recent developments in this field.

I would like to add that the Reference Committee considered this a most important function of the Association at this time, and furthermore we believe that the three articles mentioned in the report of that Committee, in regard to civilian preparedness, particularly in regard to the use of atomic weapons, should be published in The Journal of the Medical Association of Georgia.

The Committee on Medical Education and Hospitals: It has come to the attention of your Reference Committee that many unregulated and substandard hospitals are being operated in the State of Georgia, and it is our recommendation that this Committee bring forcibly to the attention of the State Board of Health such action that should be taken to correct this dangerous condition.

We commend Dr. Kelly for his personal interest in improving medical education in hospitals throughout the State.

The Tuberculosis Committee report: We recommend the adoption of the report, and recommend that this Committee continue its efforts in the control of tuberculosis.

Report of the President of the Woman's Auxiliary: Your Reference Committee, realizing the earnest and sincere effort put forth by the Woman's Auxiliary to aid and assist the Medical Association of Georgia and its members in the promotion of better public relations, wishes to commend most highly the work of the President, Mrs. L. W. Williams, and all her

committees and members. Furthermore, we express the sincere hope that the Auxiliary will continue to carry on its wonderful and vital work.

It is the recommendation of this Reference Committee that the sum of \$600 per annum be appropriated for the purpose of enabling this organization to publish a bulletin.

The report of the Committee was adopted as a whole.

Report of Committee on Awards by Secretary Shanks

First Prize: Dr. J. Calvin Weaver, of Atlanta, for his exhibit on "Medical History".

Second Prize: Department of Medicine, Medical College of Georgia, N. Reeves, C. L. Leedham and V. P. Sydenstricker, of Augusta, for the exhibit on "Viral Hepatitis".

Third Prize: Department of Medical Illustration, A. O. Parkes, and Department of Endocrinology, Medical College of Georgia, Robert B. Greenblatt, of Augusta, for the exhibit no "Vulvar Luminescence".

Honorable mention was given to Dr. W. S. Flanagan, of Augusta, for the exhibit on "Plastic Surgery".

Honorable mention was also given to Drs. Nelson H. Brown, Sarah L. Clark and M. L. Moss, of Augusta, for their exhibit on "Results of Prolonged ACTH Therapy (7.945 mg.) in a Patient with Pan-Hypopituitarism".

Motion to express appreciation to Committee on Revision of Constitution and By-Laws passed unanimously.

Adjournment.

GENERAL SESSIONS

PROCEEDINGS OF THE GENERAL SESSIONS OF MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA HELD IN AUGUSTA, APRIL 18-20, 1951

First Meeting—Wednesday 8:30 A.M.

The opening session of the One Hundred First Annual Session of the Medical Association of Georgia, held at the Bon Air Hotel, Augusta, April 18-20, 1951, convened at 8:45 a.m., Dr. Alpheus Maynard Phillips, President, presiding.

Invocation—Rev. Zach C. Hayes, pastor of St. John's Methodist Church, Augusta.

Address of Welcome—Dr. Thomas W. Goodwin, president, Richmond County Medical Society, Augusta.

Mr. President, fellow members of the Medical Association of Georgia, distinguished guests, ladies and gentlemen: It is with pardonable pride, I assure you, that I extend to you on behalf of the Richmond County Medical Society and on behalf of the City of Augusta a hearty welcome to the 101st annual meeting of the Medical Association of Georgia.

The members of our local committees have worked earnestly in cooperation with the various agencies of the State Association in an effort to make this one of the best and most profitable conventions we have ever had. To these I wish publicly now to extend my sincere thanks. We all hope that things will go smoothly, and that you will enjoy yourselves and will be able to mix pleasure with business to the utmost degree.

This staid old city of Augusta probably will not be much longer the delightful pleasure to live in or to visit that we all have known. Even now she is in the birth pangs of being transformed from an old southern city into a bustling metropolis. These changes are coming about due to factors which we can neither control nor like, and what the end result will be no one knows. What we see going on here now can but serve as a reminder of the tremendous changes which are taking place daily in all our lives.

These changes will affect us as doctors as well as individuals, and for this reason we need organizations like the Medical Association of Georgia more than ever. It is an old organization, now in its second century of service; but I make hold to say that never in all its long history has the challenge before it been greater.

It is up to us, its members, to improve it, strengthen it, and use its facilities as never before. Its public relations program needs to be supported as firmly as possible by each one of us, for I feel and I know you must feel that something is radically wrong between the medical profession and the people of America. True enough, the people have not yet permitted the obstructing hand of the politician to lay itself upon the free practice of medicine by the individual doctor, but the battle is not yet won. It is only well begun.

I believe, if I am correct in my premise, that there is something radically wrong between the people and the doctors. It follows, then, that we must be prepared to accept our rightful share of the blame for this situation. Since we are meeting this year in a medical center, let us begin with medical education itself; and what better place is there to make our beginning? What I am concerned about is the lack of evidence that our educators are aware of the tremendous need for training doctors in human and public relations.

A streamlined 1951 model of the well-trained doctor can make a difficult diagnosis and direct the therapy. If he is trained to do a lung or brain operation, he can do it well. In short, he is a first-class scientific product, "ready and willing to do". But he has not been taught, either in medical school or in the hospital, to become a part of the community, one of the people. There is a gulf, deep and wide, between him and his potential patients.

In his office he is like a babe in the woods. He knows little or nothing of office organization, of handling patients, or of how to charge and collect. He simply does not know that it is not enough to do a good scientific job. He is a bungling novice in the art of human relations with his patients, who, after all, are his greatest assets and medicine's stock in trade.

In the community at large he is no better. He tells his fellow citizens that he does not have time to help with the character building agencies and civic enterprises that make the town or city a better place for his wife and children to live in. He believes that the Chamber of Commerce, which brings many potential patients to him and his fellow doctors, should be run and supported by laymen or somebody else.

When the self-sacrificing solicitor for the Community Chest finally runs him down, he makes a token gift much as if he were tossing small change in a collection plate. Such criticism is meant to be constructive, and is to emphasize the lack of training in this area, rather than to belittle the young doctor.

Such conduct, in and out the the office and hospital, is well known, and frequently discussed by lay people of his community. If he were the only one who suffered as a result, it might be simple justice; but the fact is that it is just such failures in the realm of personal and public relations that have nearly cost us our medical freedom.

Another area in which we have done a sorry job is in professional self-discipline. The doctor who has a license to practice medicine and joins a county medical society is usually fixed for life. Unless he is convicted by a court for some criminal offense, he can continue to enjoy the rights and privileges of responsible doctors even though he, himself, practices overcharging, neglect of patients and nonsupport of organized medicine.

Such practices should not only be considered intolerable by the good doctors, but should be condemned and properly dealt with by an honest, competent and nonpartisan court of medicine. Grievance committees are now operating in more than twenty states, and the American Medical Association is taking steps in the right direction. All of this constitutes one of the most interesting experiments of modern times.

A third area in which we need to clean our own house is in the medical practice acts which in many states permits doctors to carry out procedures, operative or otherwise, for which they are neither trained nor competent. I am not speaking about criminal abortion, violation of the Harrison Narcotics Act or other like offenses; neither am I thinking about the honest mistakes that each of us makes every day. I am referring to the medical man or surgeon, usually in the small hospital, who cannot or will not make proper studies to arrive at a diagnosis or have a diagnosis made. Often these men are responsible for the health of hundreds of people.

It should be perfectly clear to anyone that if the people cannot convince themselves that organized medicine is taking vigorous steps to correct its own shortcomings, they will insist that the initiative for action be transferred to other hands.

We can win the fight for medical freedom if and when we decide to look after our own business. This means sacrifice, hard work and devotion to organized medicine. Above all else, it means that liberty is possessed only by those who earn the right to be free and employ that freedom in such a fashion as to maintain and enhance the respect and confidence in which the physician is held by his community.

Response—Dr. Charles H. Richardson, Macon

On behalf of the Medical Association of Georgia we wish to thank you, Dr. Goodwin, for your offer of generous hospitality. On the record your perform-

ances we feel sure that the present occasion will be a most delightful one, and we are looking forward to it with much pleasure.

Nominations for Officers

The names of the following members were placed in nomination for the Officers of the Association:

President-Elect—Dr. C. F. Holton, Savannah.

First Vice-President—Dr. Robert C. McGahee, Augusta.

Second Vice President—Dr. H. Ansley Seaman, Waycross.

Secretary-Treasurer—Dr. Edgar D. Shanks, Atlanta; Dr. David Henry Poer, Atlanta.

Delegate to AMA (term to expire Dec. 31, 1953)—Dr. Charles H. Richardson, Macon.

Alternate Delegate to A.M.A. (term to expire Dec. 31, 1953)—No nomination.

Councilor for Ninth District—Dr. Bruce Schaefer, Toccoa.

Councilor for Tenth District—Dr. Harry L. Cheves, Union Point.

By ruling of President Phillips the following were appointed as members of the Tellers Committee: Dr. J. W. Chambers, LaGrange, Chairman; Dr. George H. Alexander, Forsyth, and Dr. B. H. Minchew, Waycross.

Report of Committee on Revision of the Constitution and By-Laws

Dr. Allen H. Bunce, Atlanta, Chairman, presented the proposed new Constitution and By-Laws in the form of a printed pamphlet with a copy for each member. This constituted the second reading of the proposed new Constitution and By-Laws.

Adjournment.

Second Meeting—Friday 12:15 P.M.

The final General Session convened at 12:15 p.m., with President Phillips presiding.

Report of the Secretary of the House of Delegates, Dr. Edgar D. Shanks

The total number of physicians attending this session was 602, of whom 60 were visiting physicians. Miscellaneous visitors, 9; exhibitors, 73; members of the Woman's Auxiliary, 195. The grand total was 879 persons registered for the meeting.

The dues for next year were set by Council at \$15.

The following appropriations were made by Council:

Public Relations Department.....	\$15,000
Better Health Council	1,000
Woman's Auxiliary	600

Report of Secretary approved unanimously.

Report of the Committee on Revision of the Constitution and By-Laws, Dr. Allen H. Bunce, Atlanta, Chairman

The new Constitution and By-Laws as presented for the second reading at the Wednesday general session and with changes made by the House of Delegates was adopted unanimously.

Resolution of Thanks, Past President C. L. Ayers, Toccoa

The 101st session of the Medical Association of Georgia here in Augusta has been one of the most successful and most enjoyable meetings we have ever had. Every minute of the time has been spent with profit and pleasure. I would like to have recorded in our minutes a resolution of thanks to the Richmond County Medical Society, the Woman's Auxiliary and all others who have contributed to the success of this meeting.

Announcement by President Phillips.

The Fifty Year buttons and certificates will be mailed to all men entitled to them.

Selection of meeting place for 1952 session.

The invitation of the Fulton County Medical Society, Atlanta, extended by Past President W. A. Selman was accepted unanimously.

NEWS AND INFORMATION

OF

GENERAL MEDICAL INTEREST

MEETINGS

CALENDAR:

FOURTH ANNUAL POSTGRADUATE COURSE FOR GENERAL PRACTITIONERS, sponsored by Emory University School of Medicine and the Medical Association of Georgia. Dr. Russell H. Oppenheimer, 36 Butler St., S. E., Atlanta, Director.

OBSTETRIC SEMINAR, sponsored by Medical College of Georgia and Bureaus of Maternal and Child Health, South Carolina, Georgia and Florida State Health Departments, Sheraton-Plaza Hotel, Daytona Beach, Fla., Sept. 10-12.

GEORGIA CHAPTER OF AMERICAN ACADEMY OF GENERAL PRACTICE, Hotel Dempsey, Macon, Oct. 25. Dr. Walter W. Daniel, 743 West Peachtree St., N. E., Atlanta, President.

GEORGIA DIVISION, AMERICAN CANCER SOCIETY, Bon Air Hotel, Augusta, October 18. Dr. J. Elliott Scarborough, Emory University Hospital, Emory University, Chairman.

GEORGIA CHAPTER AMERICAN COLLEGE OF SURGEONS, Bon Air Hotel, Augusta, October 18. Dr. James H. Semans, 34 7th Street, N. E., Atlanta, Acting Secretary.

GEORGIA HEART ASSOCIATION, Hotel Oglethorpe, Savannah, Sept. 14-15. Dr. J. Frank Harris, Medical Arts Building, Atlanta, Secretary.

GEORGIA ORTHOPEDIC SOCIETY, Bon Air Hotel, Augusta, October 18. Dr. John I. Hall, 666 Cherry Street, Macon, Secretary.

GEORGIA PEDIATRIC SOCIETY, ACADEMY OF MEDICINE, Atlanta, Oct. 11. Dr. Harry Lange, 490 Peachtree St., N. E., Atlanta, Secretary.

GEORGIA RADIOLOGICAL SOCIETY, Bon Air Hotel, Augusta, October 18. Dr. Robert Pendergrass, Americus, Secretary.

GEORGIA STATE OBSTETRICAL AND GYNCOLOGICAL SOCIETY, Augusta, October 18. Dr. Jule C. Neal, Jr., 203 Professional Building, Macon, Secretary.

GEORGIA STATE SOCIETY OF ANESTHESIOLOGISTS, Bon Air Hotel, Augusta, October 18. Dr. Perry Volpito, University Hospital, Augusta, Secretary.

GEORGIA UROLOGICAL ASSOCIATION, Bon Air Hotel, Augusta, October 18. Dr. Reese C. Coleman, Jr., 490 Peachtree, Atlanta, Secretary.

INTERNATIONAL COLLEGE OF SURGEONS, United States Chapter, Palmer House, Chicago, Sept. 10-13. Dr. William Perrin Nicolson, Jr., 478 Peachtree St., N. E., Atlanta, Regent for Georgia.

SOUTHERN MEDICAL ASSOCIATION, Dallas, Texas, Nov. 5-8. Mr. C. P. Loran, Secretary-Manager, Empire Building, Birmingham 3, Ala.

This year the Obstetric Seminar annually sponsored by the Medical College of Georgia and the Bureaus of Maternal and Child Health of South Carolina, Georgia, and Florida State Health Departments will be held at Sheraton Plaza Hotel, Daytona Beach, Fla., September 10-12 inclusive. The meeting is approved for credit hours by the Academy of General Practitioners.

Lecturers will include: Dr. Gordon Douglas, New York, Professor of Obstetrics, Cornell Medical School; Dr. Edith L. Potter, Chicago, Associate Professor of Pathology, University of Chicago; Dr. F. B. Carter, Durham, N. C., Professor of Obstetrics, Duke University; Dr. Carl Huber, Indianapolis, Ind., Professor of Obstetrics and Gynecology, Indiana University; Dr. Fred L. Adair, Chicago, Emeritus Professor of Obstetrics and Gynecology, University of Chicago; Dr. Charles C. Chapple, Philadelphia, Associate Professor of Pediatrics, University of Pennsylvania Hospital; and Dr. Warren W. Quillian, Miami, President-elect of the American Academy of Pediatrics. Dr. Richard Torpin, Augusta, Dr. Charles Upshaw, Atlanta, and Dr. Perry Volpito, Augusta, will be speakers representing Georgia.

There is no registration fee, and programs are available on request at the Georgia Department of Public Health.

The Program Committee of the Georgia Society for Crippled Children, Inc. has recently held a series of working conferences seeking recommendations concerning the greatest unmet need in the field of service to crippled children in Georgia. Mrs. Leonard Haas, Atlanta, Chairman, stated that the committee is attempting to develop a program of both immediate and long range goals for the Georgia Society that will be sound and of the greatest service possible to crippled children and not a duplication of services being offered by an existing agency.

The groups consulted were the professional representatives in the State working in the field of medical and educational services to crippled children and also representatives of state organizations and agencies closely related to and vitally interested in the development of the best program possible for Georgia's crippled children.

A *Cancer Symposium* was held at the *West Georgia Cancer Clinic*, LaGrange, July 18, which was sponsored jointly by the West Georgia Cancer Clinic, the Georgia Division of the American Cancer Society and the Georgia Department of Public Health. Dr. Enoch Callaway, Director, announced that Dr. Murray M. Copeland, Professor of Oncology, Georgetown University School of Medicine, Washington, was guest speaker and led the general discussions in the afternoon, and presented a paper in the evening entitled "Precancerous Lesions of Breast." Appearing on the afternoon panels were Drs. Hoke Wammock, Augusta, J. Elliott Scarborough and Wadley Glenn, both of Atlanta. There were presentations of patients and cases as follows: Dr. B. Hollis Hand, "Tumors of the Breast"; Dr. Kenneth D. Grace, "Osteosarcomas"; Dr. Enoch Callaway, "Carcinoma of the Tongue"; Dr. W. W. Hendricks, "Virus Papillomas of Cervix Suggesting Carcinoma. Occurring During Pregnancy"; Dr. C. Mark Whitehead, "Carcinoma of Prostate"; Dr. H. H. Hamilton, Jr., "Carcinoma of Larynx", and Dr. William B. Fackler, Jr., "Leukemia".

Ladies were invited and a program was arranged for their benefit. A Dutch huffet supper was served.

MEDICAL COLLEGES

Dr. Peter B. Wright, Augusta, Professor of Orthopedics, Medical College of Georgia, has been invited to appear on the program of the Pan-Pacific Surgical Association, which meets in Honolulu November 12-19. He will also present a Scientific Exhibit entitled "Osteitis Deformans" at the same meeting.

Many surgeons and their wives are planning to attend this meeting which follows directly after the Clinical Congress of the American College of Surgeons in San Francisco November 5-9.

Dr. G. Lombard Kelly, Augusta, president, Medical College of Georgia, has been made a senior councilor for the newly formed Student American Medical Association and attended the Executive Council meeting of that organization on May 11.

Both Georgia medical schools were represented in the Unitarian Service Committee's 1951 medical mission to Japan. *Dr. Paul Beeson*, Professor of Medicine, Emory University School of Medicine, served as chairman of a 12-man group and participated in the teaching of internal medicine. *Dr. Perry P. Volpitta*, Professor of Anesthesiology, Medical College of Georgia, gave instruction in his specialty. The members of the medical mission conducted various types of teaching exercises in 12 different medical schools during a 6-week period in May and June. The mission was sent to Japan at the request of the Section on Preventive Medicine, General Headquarters, Allied Forces in Japan.

Emory University School of Medicine in cooperation with the Medical Association of Georgia announces the *Fourth Annual Postgraduate Course for General Practitioners* to be held Oct. 8-12, 1951, at Grady Memorial Hospital, Atlanta. The program will be printed in the September number of THE JOURNAL.

Georgia surgeons were interested to learn that *Dr. Nathan Womack*, a native of Reidsville, N. C., recently Professor of Surgery at State University of Iowa College of Medicine, Iowa City, will return to his native state as Professor of Surgery in the University of North Carolina School of Medicine at Chapel Hill.

Also an "adopted" Southerner, *Dr. Carl A. Moyer*, who has been Professor of Experimental Surgery at the Dallas Branch of the University of Texas School of Medicine, will become Professor of Surgery at Washington University School of Medicine, St. Louis, in October. *Dr. Evarts Graham*, world renowned Surgeon will become Emeritus Professor at that time.

Dr. Evangeline Papageorge, Atlanta, Associate Professor of Biochemistry in the Emory University School of Medicine, sailed June 11 from Hoboken, on the SS *Nea Hellas* to spend the summer in Greece.

The Certificate of Merit for the Section on Obstetrics and Gynecology was received for the exhibit "The Etiologic and Diagnostic Factors in Cervical Cancer," presented by *Dr. H. E. Nieburgs* and *Dr. Edgar R. Pund*, Augusta, Medical College of Georgia, at the A. M. A. meeting in Atlantic City, June 11-15.

A weekend short course in **Radiological Safety and Health** will be given at Emory University Medical School in the junior lecture room, Grady Hospital, Atlanta, August 17, 18 and 19. Physicians and technicians who work with x-ray machines are invited to attend. Latest information on radiological health practices will be presented. For information write or call *Dr. Lester M. Petrie*, Georgia Department of Public Health, Atlanta 3.

Dr. Jane A. Russell, Assistant Professor of Biochemistry in the Emory University School of Medicine, has returned from Atlantic City where she attended a meeting of the Association for the Study of Internal Secretions. She is vice-president of the association.

More than 200 Negro doctors and dentists from various parts of Georgia met in Augusta June 11-16 to attend the annual meeting of the Georgia State Medical and Pharmaceutical Association. Sessions were held in the Dugas Auditorium at the Medical College of Georgia.

Delegates to the convention included 100 and more doctors and 100 and more dentists. A featured speaker was *Dr. Helen W. Bellhouse*, Atlanta, consultant for the division of maternal and child health of the Georgia Department of Public Health. *Dr. T. W. Josey*, president of the Stoney Medical Association, presided at the meeting.

Members of the faculty of the Medical College of Georgia assisted in the program during the convention.

Dr. F. William Sunderman, Professor of Clinical Medicine at the Emory University School of Medicine and Director of clinical laboratories at Grady Memorial Hospital, Atlanta, will attend the International Congress of Clinical Pathology in London, England, July 16-21, as President of the American Society of Clinical Pathologists.

Dr. Sunderman will serve as Chairman at the banquet on July 20. The speech list at the banquet is as follows: His Majesty The King; *Dr. Russell Brain*, President of the Royal College of Physicians; *Dr. S. C. Dyke*, President of the International Society of Clinical Pathology; *Dr. D. Jaumain*, Belgium; *Viscount Addison*; *Sir Lionel Whitby*, President of the British Association of Clinical Pathologists, and *Dr. Sunderman*.

Dr. Morris Tager came to Emory University School of Medicine, Atlanta, on July 1 as Professor and Chairman of Bacteriology and Immunology. Following his graduation from Yale University School of Medicine and several years of hospital training, *Dr. Tager* was a member of the faculty at Yale for seven years. In 1948 he joined the faculty of the Western Reserve University School of Medicine and resigned this position to accept the appointment at Emory.

Dr. Carter Smith, Atlanta, Assistant Professor of Clinical Medicine, Emory University School of Medicine, Department of Medicine was elected Chairman of the Section of Internal Medicine of the American Medical Association in Atlantic City. This high honor comes to a Georgian for the first time in many years.

Dr. R. Bruce Logue, Atlanta, Assistant Professor of Medicine, Emory University School of Medicine, was re-elected as a member of the Scientific Council to represent Georgia on the Board of Directors of the American Heart Association in Atlantic City, June 7.

Dr. G. Lombard Kelly, Augusta, was named finance chairman for the Better Health Council of Georgia at its recent meeting in Atlanta.

Medical School Enrollment. Total enrollment in the 79 medical schools this year is 26,193, compared with 25,103 last year and 23,670 two years ago. This shows a nearly 10 per cent increase in the past two years. The freshman class of 7,187 is the largest in history. Of those admitted, 9.1 per cent had grade point averages under "B minus", but excelled in qualities such as character and motivation. (This would seem to answer the repeated demands for more medical students. Increased efficiency is also constantly increasing the number of points that can be taken care of by one physician.—Ed.).

CLINICAL INFORMATION

A new drug called Mytolon, developed by Sterling-Winthrop Research Institute, which makes deep anesthesia unnecessary when muscles must be relaxed in the course of surgery, has been developed and found clinically useful in surgical operations. Mytolon has been proved more potent and safer than natural curare.

Flaxedil, a new well-tolerated curare-like compound for use in surgical and nonsurgical procedures which require muscular relaxation, has also been announced by Lederle Laboratories. It has all of the advantages of natural curare, but is easier to administer and is less apt to be followed by disturbing reactions.

Coronary Thrombosis: Strain, worry, fatigue and overwork are important factors in heart ailments, particularly in those persons who carry a heavy load in professional and business life. Rushing about, fitting one more item of business into an already crowded schedule may place more strain on the individual. The onset of coronary thrombosis is likely to occur when the body is at rest. To reduce the danger of coronary thrombosis, the wise person will fit a rest period into his day, relaxing on a cot completely, sleeping, if possible. Heavy meals should be avoided. Excessive use of tobacco seems to be a factor in some cases.

In all types of heart disease, worry should be avoided, as well as excessive muscular effort. A healthy heart is essential to long and normal life. Take care of it. The alternative is early death.

Fat Can Kill You—And there are more systems of reducing than there are pounds on the overweight men of America. But there's only one that works: To weigh less: eat less: Exercise won't take off fat. Enough violent exertion to equal a thirty mile hike will remove about 12 ounces—and will help you work up appetite enough to eat on three pounds more.

Steam bath and massage won't help much either. Steam baths are excellent for easing sore muscles—or for making you feel more relaxed at the end of a tough day. But they won't take weight off.

Everyone needs some exercise—not to reduce but to tone up the body and its muscles. Regular rhythmic exercise will boost your weight-loss program if you watch your food intake, too. Walking is one of the best exercises—and one of the easiest to take.

Fat men, appear less frequently in the divorce and criminal courts than thin men. However, they appear more frequently on the obituary page. Excess weight was one of the principal topics of discussion at the recent A.M.A. meeting in Atlantic City.

Varidase, announced by Lederle Laboratories, makes available to the medical profession for the first time an enzyme product combining Streptokinase and Streptodornase in a single clinically-proven product. Varidase dissolves clotted blood, viscous pus, and fibrinous accumulations within the body. It is useful in surgery and in skin grafting by aiding in the removal of dead tissue and hastening tissue regrowth. Furthermore, it clears the way for treatment with aureomycin and other antibiotics.

Colored Glasses—The indiscriminate use of tinted glasses can prove harmful, the Educational Committee of the Illinois State Medical Society cautions in a **Health Talk**, particularly the cheaply manufactured glasses. The normal, healthy eye does not need colored glass for protection against the sun's rays, any more than it needs a glass for better vision. The person who merely wears the tinted lens because the sun is shining is apt to weaken the normal adjustment of his eyes.

HOSPITALS

Dr. Cleveland D. Whelchel will head the medical staff at the new Hall County Hospital, Gainesville, according to an announcement made by Dr. Billy S. Hardman, president of the Hall County Medical Society. Vice chief of staff will be Dr. Bradley B. Davis and the secretary-treasurer, Dr. C. W. Whitworth. Members newly elected to the executive committee are Dr. Clarence G. Butler, Dr. W. R. Garner, Dr. H. E. Valentine, Jr., Dr. Whelchel, Dr. Davis and Dr. Whitworth. The hospital opened following dedication ceremonies on August 1.

Dr. Ralph Fowler recently was named president of the medical staff at Kennestone Hospital, Marietta, succeeding Dr. Mayes Gober. Elected vice-president was Dr. W. C. Mitchell and secretary Dr. Murl Hagood. Dr. Fowler is the past vice-president while Dr. Mitchell is the past secretary.

GOVERNMENT

CHANGE NAME OF U. S. MARINE HOSPITALS. As of July 1, the U. S. Marine Hospitals will be officially designated U. S. Public Health Service Hospitals. It was explained that while Merchant Seamen and the other service beneficiaries know and understand the mission of the marine hospitals, the public frequently associates them with the U. S. Marine Corps. Historically, the name marine hospital goes back over 150 years to the time when they cared for seafarers only. Since then, Congress has added to the list of service beneficiaries, and today more than half the patients come from groups other than seamen.

LOW DEATH RATE OF ENEMY PRISONERS DUE TO ARMY MEDICAL SERVICE TREATMENT.—Death among Communist prisoners of war treated by the U. S. Army Medical Service at hospitals in Korea for battle wounds and injuries, over a six months period, have been only seven per cent. The death rate among American wounded receiving medical attention in World War I was eight per cent. In sharp contrast to the medical attention given United Nations troops and the common hygienic precautions taken by UN personnel is the lack of attention given to preventive medicine by the enemy.

The following is a list of Naval Reserve Officers who have been recalled to active duty from Georgia to date: Dr. Waddell Barnes, Macon; Dr. Jas. Henry Brown, R.F.D. 1, Rossville; Dr. Clyde Allen Burgamy, Augusta; Dr. J. Lewis Cannon, Dept. of Physiology, Emory University; Dr. John Gordon Morrow, Jr., Ahira; Dr. Alexander Thos. Murphey, Jr., Augusta; Dr. Thos. Campbell Nolan, Macon; Dr. Wm. Vance Watt, Thomasville.

These Georgia Physicians have been recalled as Air Force Reservists: Calk, Guy L., Macon; Cline, Peter J., Atlanta; Dickey, Lovick E., Jr., Sylvania; Forester, Beverly W., Macon; Garner, Frank L., Atlanta; Goldin, Harold W., Rockmart; Guilbeau, Joseph A., Jr., Atlanta; Hearn, Henry B., 3d, Augusta; Jones, Henry B., Jr., Macon; Logue, John T., Augusta; Martin, Talmage M., Jr., Bowdon; Meeks, Calvin S., Jr., Douglas; Munro, Louis A., Columbus; Newsom, Bruce C., Augusta; Newton, Ralph G., Jr., Macon; Pennington, Claude L. Jr., Macon; Roche, William P. Jr., Chamblee; Rollings, Harry E., Savannah.

RECOMMENDATION FOR DEFERMENT OF MEDICAL AND DENTAL TECHNICIANS: Under the provisions of Public Law 779, State and Local Advisory Committees responsible for furnishing advice to local Selective Service boards regarding deferment of all allied specialist categories "whose activity in study, research or medical, scientific or other endeavors, is found to be necessary to the maintenance of the national health, safety or interest."

SELECTIVE SERVICE CALL FOR PHYSICIANS: During July, August and September the Selective Service System will fill the calls made on it by notifying the youngest individuals in Priority I who are classified in Class 1-A that they should apply for a commission at once.

The individuals who are named on the Selective Service Calls should be advised to apply for a commission at once. The Army and Air Force expect to process them in sufficient time to avoid any inductions; in fact, if they are delayed in the processing they are to notify the local board to postpone induction until the processing is complete. However, once these individuals receive their commissions they should take their Oath of Office within 72 hours and notify their local boards since otherwise they will be inducted as privates.

REPORT OF NATIONAL DOCTORS COMMITTEE FOR IMPROVED FEDERAL MEDICAL SERVICES: The doctors of this country are faced with a responsibility to make their voices heard in the forthcoming discussion that will result from Congressional consideration of the bills affecting federal medical services.

These bills, (S. 1140 and H.R. 3305 and 3688) if enacted, would create a new Department of Health, with Cabinet status which would unify and bring under one central control the thirty-odd medical systems of the government.

There is no doubt that this unification is needed or that some plan will probably be adopted to correct it; perhaps that legislation, which follows recommendations of the bipartisan Hoover Commission, or some other method yet to be advanced.

The point is that this question of national importance should be of greater interest and concern to the doctors than to any other group. It is therefore desirable, in fact essential, that the thinking of the medical profession be explored and the opinions of its members be brought to the attention of Congress before that body acts upon any legislation.

One thing is sure. Unless the doctors make their position clear, some legislation might be engineered by lay groups which not having the doctors' point of view, might do them a disservice.

For these reasons the National Doctors Committee for Improved Federal Medical Services has been created. It is a fast-growing, nationwide politically nonpartisan body of medical men with the welfare of their country and their profession at heart. It is not a pressure group and not a lobby.

The policies of this committee are being formulated by an advisory committee of doctors representing all branches of medicine and many parts of the country.

It may be that doctors generally are not aware of the situation that exists in the vast conglomeration of the Federal Medical Services. They may not realize the unnecessary waste of scarce medical manpower that results from the duplication of skills by five major and 30 smaller medical systems controlled by the government.

The Army, Navy, Air Corps, Veterans Administration and the Public Health Service are conducting independent and competing hospital systems which are not coordinated. They compete for appropriations from Congress, for medical specialists, for nurses and for supplies. This results in vast waste of men and material and the system is costing the taxpayers \$2 billions a year.

There is no central authority or supervision over the separate systems and there is no plan for the transport of medical personnel or equipment in the event of a great emergency such as an air attack. There is no law making such coordination possible.

Some of these units, notably the Veterans Administration, build hospitals in areas where it is impossible to staff them and sometimes spot a new hospital in an area where an institution of one of the other units is being shut down.

The whole country has been made conscious of the danger of possible atomic attack. We have organized defense systems, established air raid warning signals and bomb shelters. But what is going to happen to the populations of bombed areas? An air attack would probably destroy the local hospitals and, if they were spared, would conceivably result in casualties far outnumbering the available beds and overwhelming the local physicians. There is the Red Cross, but as a voluntary organization it might lack the authority needed in such an emergency. Fine as it is, it might not, alone, be able to cope quickly with a catastrophe of the magnitude, from experiences in Japan, such a bombing would assume. It might require the full weight and authority of government hospital services.

While there are various opinions about whether or not we have an actual shortage of doctors, there is no doubt that their distribution, especially into the armed services, is having an effect in many sections.

These are matters which the committee believes doctors should take to heart, to ponder and to be able to voice their opinions when they come before the Congress for solution.

ROBERT COLLIER PAGE, M.D.

CIVILIAN MEDICAL CARE FOR ARMY PERSONNEL

One of the services furnished the American soldier is adequate and timely medical care and treatment, including hospitalization. This service is provided generally by dispensaries, infirmaries, and hospitals located at the Army installations. There are some locations, where Army or other

United States federal medical treatment facilities are not available when medical service is required by Army personnel. In cases of this nature, the services of civilian physicians, clinics, and hospitals are necessary. With the expansion of the Army and the deployment of Army personnel to practically all points in the United States either on a duty, travel, or leave status, the continued cooperation of civilian physicians and agencies is of utmost importance in providing adequate medical service to the U. S. soldier in time of need.

Certain criteria and procedures have been established in connection with the furnishing of medical service to Army personnel by civilians in accordance with the current laws and regulations. These criteria define the conditions under which individuals of the Army may be authorized civilian medical care at the expense of the Army. These procedures include methods for reporting and receiving payment for treatment or hospitalization of Army personnel by civilian medical agencies.

Civilian medical care (other than elective) at the expense of the Army is authorized for officers, and enlisted personnel when these personnel are on a duty status or when they are on leave or informal leave (pass) status. Applicants for enlistment in the Army and selectees also are authorized necessary civilian medical care at the expense of Army funds while they are being processed for enlistment or induction into the Army. Payment for civilian medical expenses incurred by Army personnel who are absent without leave is not authorized.

Normally, civilian medical care for Army personnel is authorized only when there are no other federal medical treatment facilities available. First aid or emergency treatment is authorized at any time, notwithstanding the proximity of Army or other federal medical treatment facilities. In this connection, emergency medical care may be defined as that required to save life, limb, or prevent great suffering. Surgical operations should not be performed without prior approval of military authorities, unless indicated as an emergency procedure. Elective medical treatment in civilian medical treatment facilities or by civilian physicians will not be authorized as Army funds cannot be used for payment of these services.

Due to limitation of funds available to the Army, medical care of dependents of military personnel by civilian doctors at Army expense, is not authorized. Dependents of military personnel may obtain available medical care at Department of Defense medical facilities only.

For emergency cases treated without prior written authorization, the surgeon of the nearest military command should immediately be notified by the civilian physician, giving the individual's name, organization, nature of illness or injury and statement of the practicability of transfer of the patient to an Army or other governmental hospital. The civilian agency or physician then will be advised without delay by the appropriate military authorities as to procedures to be followed.

Bills for authorized medical care and treatment of Army personnel should be submitted to the commanding officer of the organization to which the patient belongs, or to the military authority who provided the authorization for the medical service. If the location of these individuals is not readily known or if such military commanders authorizing treatment have moved to another

station, the bill should be sent to the military authorities listed below.

Georgia: submit bill to The Surgeon, Third Army, Fort McPherson, Ga.

The bill should show the full name, rank, and service number of the patient, place, and inclusive dates of treatment, diagnosis, and charges, all itemized separately. The duty status of the patient at the time of illness or injury also should be shown, such as duty, leave, or pass. Payment will be expedited if the following certificate is typed on the bill and signed:

"I certify that the above charges are correct and just; that payment therefor has not been received; that the services were necessary in the care and treatment of the person named above; that the services were rendered as stated; and that the charges do not exceed those customarily charged in this vicinity."

(Signature of Payee)

(Title or Capacity)

Answers to specific questions or further information concerning this matter may be requested of the military surgeon at the above address or from The Surgeon General, Department of the Army, Washington 25, D. C. Any difficulties that are experienced should be called to the attention of these Army authorities in order that this program may function smoothly and render the American soldier the prompt and adequate care and treatment to which he is entitled.

(An abstract from an outline submitted by the Surgeon General.—Ed.)

MISCELLANY

McCormick Thanks Elks for Medical Aid. Dr. Edward J. McCormick, Toledo, member of the A.M.A. Board of Trustees, last week thanked the million members of the Benevolent and Protective Order of Elks for their interest in medical care for the underprivileged, and their pioneer interest in the field of aid to crippled children and the cerebral palsied. The Elks held their annual convention in Chicago.

Dr. McCormick said members of the Elks believe that the American system of free enterprise is the only safe way of solving the nation's problems, not only in the field of medicine, but in all fields of life. The Elks, he said, are opposed to communism and socialism and its members feel that Americanism can best be served by voluntary agencies devoting every effort to make the dependent independent.

A. M. A. Panel Offers Ideas to Help "Aging" America. Programs to train over-age employees for retirement offer American business an opportunity to help solve the nation's growing problem of an aging population, according to Philip N. Scheid, of the Pullman-Standard Car Manufacturing Company, Chicago.

The symposium on aging was held at the AMA convention and included Dr. Robert A. Moore, Dean, Washington University, St. Louis; Dr. Leonard E. Himler, neuropsychiatrist, Ann Arbor; Prof. Clarence J. Velz, School of Public Health, Michigan University; Dr. Charles Franco, associate medical director of Consolidated Edison Company; Miss A. Randall of the Community Service Society of New York; Mr. Scheid and Dr. T. G. Klumpp, Winthrop-Stearns, New York, presided.

"It is possible for us to strike down, one by one, the diseases that ride in on the coat-tails of old age. Second, much more will be done to

extend the average life span beyond what it is today, said Dr. Klumpp.

"From the moment of conception, our bodies live by reason of chemical processes. The job, therefore, is to find out how the chemistry of Christian Jacob Dragenberg, who lived to 146, differs from that of John Jones, buried at 42, all of whose organs showed the effects of extreme arteriosclerosis."

Dr. Franco said that if industry continues its present retirement practices, it will be faced with a seriously depleted labor pool, and top-heavy pension costs. Since the turn of the century, he said, the number of those over 65 has quadrupled while the population has only doubled.

He urged rehabilitation of workers of any age who are chronically disabled by heart disease, arthritis and tuberculosis, so that their remaining physical capacities may be used and their working life-span lengthened.

CORRESPONDENCE

To The Editor:

In accordance with your request, I am outlining briefly the developments of the work done up to date by the Georgia Commission on Alcoholism. The Bill as passed, without opposition, in the last session of the State Legislature was signed by the Governor in March 1951, and provides for the following:

1. The average alcoholic should be treated as a sick person who deserves medical treatment and rehabilitation. He should not be treated as one deserving punitive measures.

2. The Commission is empowered to buy land, build hospitals or clinics, equip and staff them for the treatment and rehabilitation of alcoholics. The Commission is also empowered to contract for private facilities for the treatment and rehabilitation of alcoholic patients.

3. The Commission is empowered to appoint and fix the compensation of a Medical Director for the program, as well as other professional personnel that may be needed.

4. The Commission's operations will be financed by the appropriation of funds to be paid out of the General Funds of the State.

The Program is all inclusive and the Commission is checking and utilizing all of the experience of other states that have developed similar programs and have them in operation.

As far as we can determine, the Georgia Commission will utilize existing hospital facilities wherever possible for in-patient and out-patient treatment in the hope of developing the most complete hospital treatment possible. Of course, this contemplates using the sources of private family physicians where possible, as well as that of existing psychiatric trained workers now employed in other state agencies.

We do appreciate the very fine spirit of cooperation and assistance of the Medical Association of Georgia. We shall be delighted to keep your office informed as to our developments and the methods and procedures used by other states.

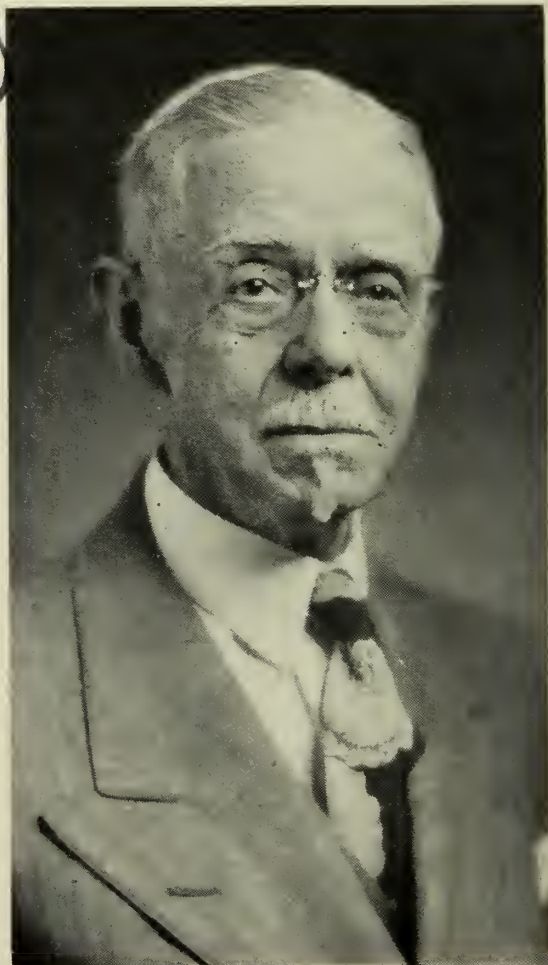
We will have to have a recommended program ready for the next session of the General Assembly in January and will appreciate such publicity as you can give the program through your Journal of the Association.

Sincerely yours,
PAUL H. FRASER, Chairman,
Georgia Commission on Alcoholism.

PERSONALS

Dr. W. L. Champion, Atlanta, continues practicing medicine after 60 years. A merry-eyed, goateed, 83-year-old Atlanta physician, who recalls performing operations on dining-room tables by kerosene lamp light when he began his practice was honored recently.

Dr. Champion, admittedly the "oldest urologist in Georgia," was honor guest at a dinner at East Lake Country Club given by an associate, Dr. Major F. Fowler. The entire membership of the Fulton County Medical Society was invited to pay tribute to Dr. Champion, one-time "horse and buggy" doctor and now a distinguished specialist in his field. The occasion also marked his 83rd birthday.



WILLIAM LEON CHAMPION, M.D.

Dr. Champion has served as president of the Fulton County Medical Society, the Atlanta Urological Society and the Georgia Urological Association.

Dr. William (Bill) Purcell, of Jefferson, announces that he has joined the staff of the Johnston-Hall Hospital, Calhoun, for the practice of medicine and surgery.

Dr. Herbert W. Burton announces the opening of his offices at 85 Merritts Avenue, N. E., Atlanta. Practice limited to internal medicine.

Dr. Osler A. Abbott, Emory University, was elected Governor of the American College of Chest Physicians for Georgia, and Dr. Carl C. Aven, Atlanta, was elected Historian at the 17th Annual Meeting held in Atlantic City, June 7-10.

Dr. Darnell L. Brawner, a native of Hamilton, announces the opening of his office at 513 Whitaker Street, Savannah, for the practice of obstetrics and gynecology. He received his medical degree from Emory University School of Medicine, Atlanta, in 1944. His postgraduate hospital training included a gynecological residency at Grady Memorial Hospital, Atlanta.

Dr. Robert V. Cleary, Boston, Mass., has recently reported as Chief of the Surgical Service at the Veterans Administration Hospital, Dublin.

Dr. Glenville Giddings announces the association of Dr. Glenville Arkwright Giddings in the practice of internal medicine and cardiology, 818 Doctors Building, 478 Peachtree Street, N. E., Atlanta.

It appears that the doctors are going to blaze the trail in getting Savannah men in shirt sleeves in these warm days. Dr. C. A. Henderson, city and county health commissioner, Dr. Michael J. Egan and Dr. John E. Porter, were seen recently sans coats and looking as cool as could be. Scores of other physicians have also joined the "beat the heat" movement.

Dr. Conway Hunter takes pleasure in announcing the association with him of Dr. William H. Bateman at 770 Cypress Street, N. E., Atlanta. Practice limited to obstetrics and gynecology.

Dr. George A. Holloway and Dr. John J. Barnes his offices to 104 Ponce de Leon Ave., N. E., Atlanta. Internal medicine (gastroenterology).

Dr. George A. Hilsman and Dr. John J. Barnes announce the removal of their offices from 33 Ponce de Leon Avenue, N. E. to 756 Cypress Street, N. E. (between the Peachtrees at Fourth), Atlanta.

Dr. William H. Lippitt, Savannah, spent June 13 holding clinics and giving lectures at the Veterans Administration Hospital in Dublin. His presentation entitled "Tumors of the Thyroid Gland" was a feature of the postgraduate medical course provided by the Veterans Administration for the medical staff.

Dr. Edward S. Marks, Marietta, has been certified by the American Board of Surgery, having recently passed the second part of the surgical examinations. Dr. Marks had considerable experience in surgery in hospitals in Cincinnati, Washington and Memphis before coming to Marietta.

Miss Dene Johnson, employed by the Public Relations Department of the Medical Association of Georgia, was married to Mr. John Maltbie, Jr., at the Grace Methodist Church, Atlanta, June 30. Mrs. John Maltbie, Jr. returned to her work at the Association on July 16. Congratulations and best wishes from all members of the Association go to this couple.

Dr. J. L. Nevil, who has been doing general practice in Metter since 1915, announces the opening of his new hospital, which has 12 rooms, and will serve mainly as a clinic and stork shelter. It has been named J. L. Nevil Clinic and Stork Shed.

Dr. Albert P. Ohlmacher, formerly of Royal Oak, Mich., chief of surgery for the Appling General Hospital, Baxley, was recently guest speaker at the Baxley Kiwanis Club. Dr. Ohlmacher was introduced by Dr. H. C. McCrackin, chief of the hospital medical staff. Dr. Ohlmacher is a member of the American College of Surgeons and certified by the American Board of Surgery, and during World War II, he was Lt. Colonel in charge of the Surgery Service at Battey General Hospital, Rome.

Dr. Thomas G. Ritch, deceased, of Jesup was awarded the William Murphey Trophy posthumously at the annual Lions Club Ladies Night, June 28. The award is emblematic of the devotion to community betterment and the relief of human sufferings for which Dr. Ritch strove during his life. Mrs. Ritch received the award for her husband.

Dr. Edgar D. Shanks, who has practiced medicine in Atlanta for twenty-five years, was presented a silver service Sunday afternoon (July 1, 1951) by more than 50 friends in the medical profession in appreciation of his "faithful and loyal service to medicine in Georgia."

The surprise presentation was at his home, 1431 Fairview Road, N. E., Atlanta.

Dr. Shanks served 16 years as secretary-treasurer of the Medical Association of Georgia and as editor of the Association's journal. He also has served on numerous committees of the Fulton County Medical Society and was elected to its presidency in 1935.—The Atlanta Constitution, July 2, 1951.

Dr. Z. S. Sikes, formerly of Milledgeville, has recently passed the American Board in Neuro-psychiatry, and at the present time is associated with the Veterans Administration Hospital, Roanoke, Va., as Psychiatrist, Senior Grade.

Dr. Charles W. Smith takes pleasure in announcing the association with him of Dr. Thomas A. Harris in the practice of obstetrics and gynecology at 57 Sixth Street, N. E., Atlanta.

Friends of Dr. and Mrs. E. O. Veale, Arnolds-ville, held open house in Dr. Veale's honor when friends and relatives called between the hours of three and six on Sunday afternoon, July 1. The occasion, which was held at the Veale home, marked Dr. Veale's 76th birthday, as well as celebrated his fifty years of medical service in the Arnolds-ville community. He is widely known and greatly beloved.

Dr. Edmund J. Virusky of Baltimore, Md., has joined the staff of Ritch-Leaphart Hospital, Jesup, as general surgeon.

Dr. John D. Deal announces the opening of his office for the practice of medicine in Portal.

Dr. Charles F. McKay announces his association with Dr. W. R. McCoy and Dr. J. M. Jackson at Folkston.

SOCIETIES

Baldwin County Medical Society, Milledgeville, plans to hold its meetings through the summer at bi-monthly intervals. The last meeting was in the form of a banquet, at which time Drs. Peacock and Bradford of the State Hospital, and Dr. Dawson Allen, Milledgeville, gave a very interesting discussion with reference to their recent visit to the American Psychiatric Association. The next meeting was July 9, at which time the Georgia Heart Association presented the scientific program.

The First District Medical Society met at the DeSoto Hotel, Savannah, June 22, in conjunction with the First District Heart Association. Dr. Bird Daniel, Statesboro, President, called the meeting to order. The scientific program included: "Surgical Conditions of the Chest," Dr. Thomas R. Freeman, Savannah; "Hypertensive Conditions in Pregnancy," Dr. John R. McCain, Atlanta; "Cardiovascular Complications of Surgery," Dr. Bruce Logue, Atlanta; "Diseases of the Aorta," Dr. Carter Smith, Atlanta.

Dr. Thomas P. Waring, Savannah, addressed the Georgia Medical Society on "Rotational Deformities of the Legs in Children."

The Laurens County Medical Society, Dublin, recently had Dr. Charles C. Benton, Macon, as its guest speaker. His subject was "The Newest Advances in Anesthesia."

The Sixth District Medical Society met on June 28 at the VA Hospital, Dublin. Dr. J. A. Thurston, Chief of Professional Services of the VA Hospital, and his Staff acted as hosts and presented the scientific program. These included: "Gout: Diagnosis and Management," Dr. F. D. Cheney, Chief of Medicine and Staff.

"The X-ray Gastrointestinal Series," Dr. C. J. Romeo, Chief of Radiology.

"The Cardiac Patient and Operation."

"Surgical Aspects of Peptic Ulcers."

"Demonstration of Electrodermatome."

"Sympathectomies," Dr. R. C. Cleary, Chief of Surgery and Staff.

"Experiences with Intramedullary Pin Fixation of Fractures," Dr. J. A. Coyle, Chief of Orthopedics, and Staff.

"Clinicopathological Conference," Dr. M. Fernan-Nunez, Chief of Pathology.

The Tattnall County Medical Society met recently at the country home of the President, Dr. J. M. Hughes, Glennville. Matters of business only were discussed.

The Third District Medical Society met at the Americus Country Club, Americus, June 21. The Sumter County Medical Society were hosts. The following scientific program was presented:

"Management of Rheumatoid Arthritis," Dr. Max Michael, Atlanta.

"Cancer of the Colon," Dr. Thomas Harrold, Macon.

"Early Care of Patients with Injuries," Dr. William G. Hamm, Atlanta.

"Management of Breech Presentation in Pregnancy and Labor," Dr. R. A. Bartholomew, Atlanta.

DEATHS

Dr. Barney Elliott Horton, aged 77, Atlanta physician, died April 23, 1951. Dr. Horton was a native Georgian, and graduated from the Atlanta College of Physicians and Surgeons, Atlanta, in 1900. He was an honorary member of the Fulton County Medical Society, the Medical Association of Georgia and the American Medical Association. He was also a member of the Grace Methodist Church and a Shriner. Survivors include his wife, Mrs. Barney Elliott Horton, Atlanta; one brother and two sisters. Funeral services were held at Spring Hill with Dr. Charles Allen, pastor of Grace Methodist Church and Dr. Henry H. Jones, a former pastor, officiating. Burial was in West View Cemetery, Atlanta.

Dr. LeRoy Glenn Parham, aged 63, Atlanta physician, died at his residence, July 12, 1951. Born in Hogansville, Dr. Parham came from a distinguished Meriwether County family that has been planters for several generations. He graduated from Emory University School of Medicine, Atlanta, in 1915. After serving the Medical Corps in the Army of Occupation during World War I, he practiced internal medicine in Chipley. Since 1929 Dr. Parham has maintained offices in the Medical Arts Building, and he was on the staffs of several Atlanta hospitals. He was a member of the Fulton County Medical Society, the Medical Association of Georgia and the American Medical Association. He belonged to the Peachtree Road Methodist Church, the Brookhaven Elks Club and was a Shriner. Surviving are his wife; a daughter, Mrs. Tom G. Sanford, Tampa, Fla.; a son, L. Glenn Parham, Jr., Atlanta; a brother, Virgil S. Parham, Miami, Fla., and three grandchildren. Funeral services were held at Spring Hill with Dr. Nat G. Long officiating. Burial was in West View Cemetery, Atlanta.

Dr. Lucius Pierce Farmer, aged 70, retired Stapleton physician, died May 1, 1951. Dr. Farmer was the son of the late Louis and Adeline Atwell Farmer, both natives of Jefferson County. He graduated from the University of Georgia School of Medicine, now Medical College of Georgia, Augusta, in 1906, and practiced medicine in Fargo, Baker County and Stapleton. He was a veteran of World War I and a member of the Masonic Lodge. Survivors include his wife, Mrs. Sarah Brown Farmer; two sisters; and several nieces and nephews. Funeral services were held at the Ways Baptist Church with the Rev. J. E. Cook officiating. Burial was in the Ways Baptist Churchyard Cemetery, Stillville.

Dr. George Carter Brooke, aged 60, prominent Canton physician, died suddenly due to a heart attack at his home, July 4, 1951. He was born in Alpharetta and his parents were the late Col. and Mrs. J. P. Brooke. He graduated from Vanderbilt University School of Medicine, Nashville, Tenn., in 1915. After serving in the Medical Corps during World War I he began the practice of medicine in Canton in 1917 where he practiced until his death. He was a Mason, a member of the American Legion, the Cherokee-Pickens Medical Society, the Medical Association of Georgia, and the American Medical Association, and also a member of the Cherokee County Board of Health. Funeral services were held at the First Methodist Church, Canton, with the Rev. R. B. Hawkins and the Rev. W. W. Long officiating. Burial was in the City Cemetery, Alpharetta.

NEW BOOKS

Books for review should be sent to the Book Review Department, Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta, Ga. Acknowledgement of receipt will be made in these columns, and those selected for review will be based on merit and interest to our readers.

When others fail him the wise man looks to the sure companionship of books.

—Andrew Lang

EMOTIONAL FACTORS IN CARDIOVASCULAR DISEASE: By Edward Weiss, M.D., Professor of Clinical Medicine, Temple University School of Medicine, Philadelphia. 84 pages. Price \$2.25. Publisher: Charles C. Thomas, Springfield, Ill.

The material in this small book is something that the medical profession has long needed. Emotional factors are particularly important when dealing with patients whose minds are centered on their cardiovascular system. For example, the reviewer of this book has a patient who is now approaching his 85th birthday and who at the age of 29 was told by a reputable physician that he had serious heart disease and probably would not live to the age of 45. This patient, even though he has enjoyed more than good health all these years, continues to worry about his heart.

Dr. Weiss is to be congratulated for his concise yet adequate discussion of an important subject, and his book should be possessed by every physician, even though some physicians are not interested in the subject here discussed. Publisher Charles C. Thomas, who was born on old Whitehall Street in Atlanta—let us say in the “gay nineties” when that street was one of Atlanta’s finest residential thoroughfares—also is to be congratulated for the fine make-up and for the type used in this book. Only one misspelled word was noted in the entire book, the word solely on page 21 being spelled as soley.

EDGAR D. SHANKS, M.D.

CLINICAL HEART DISEASE: By Samuel A. Levine, M. D., F. A. C. P., Clinical Professor of Medicine, Harvard Medical School; Physician, Peter Bent Brigham Hospital, Boston; Consultant Cardiologist, Newton-Wellesley Hospital; Physician, N. E. Baptist Hospital. 4th edition. 556 pages, 192 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price \$7.75.

When making comment regarding this book, one must remember that Dr. Levine’s book is not new: this is the fourth edition. One must also recognize again that the book bears the title of “Clinical Heart Disease.” All of this is interesting and important, for the reason he was one of the first American physicians to study the electrocardiogram. Indeed, it has been said of him that at the opening of Peter Bent Brigham Hospital, in Boston, he was requested by the hospital staff to visit England and confer with Sir Thomas Lewis and other distinguished British physicians regarding the purchase and installation of an electrocardiograph for the new hospital. This he did, so the story goes: he not only helped install the machine but was its official operator and was the sole interpreter of the electrocardiograms produced by it. In his experience, then, he not only learned the value of the electrocardiogram but also learned that one could not rely entirely on its use in the diagnosis and treatment of heart disease, hence his valuable book—*Clinical Heart Disease*.

EDGAR D. SHANKS, M.D.

PHYSICAL DIAGNOSIS: By Ralph H. Major, M.D., Professor of Medicine in the University of Kansas. New, 4th edition. 446 pages with 469 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price \$6.50.

Dr. Major, long a teacher of medicine and a champion of good physical diagnosis, has again revised his very fine book dealing with this subject. True, Dr.

Major’s book is not the only book available on the subject of physical diagnosis, but it can always be counted among the best and can be recommended to physicians and students alike without reservation.

EDGAR D. SHANKS, M.D.

FUNDAMENTALS OF CLINICAL FLUOROSCOPY. By Charles B. Storch, M.D., Adjunct, Radiodiagnostic Department and Radiotherapy Department, Beth-Eli Hospital, Brooklyn, New York. 196 pages, with 217 illustrations. Price \$6.75. Grune & Stratton, New York.

The purpose of this book is to present in simple, concise, and clear form the basic principles necessary for intelligent use of the fluoroscope. This fulfills a long-felt need as there is no modern text on fluoroscopy alone. True, the information is present in all of the large texts on radiology, but the average physician has neither the time nor the patience to adequately read one of these larger texts unless he limits himself to radiology.

The author begins with a discussion of the basic concepts presented in simple terms that any doctor can understand. Included in this discussion are the actual mechanics involved, the dangers of x-ray and the need for protection, and dark adaptation. All of the above topics are covered in a space of ten pages. He then proceeds with a discussion of fluoroscopy of the various organ systems.

The author’s style is good and the physical make-up of the book is the best. All in all, it makes for interesting and enjoyable reading. The book has much to recommend it to general practitioner, internist, and radiologist alike.

EDWARD M. WEST, M.D.

SPATIAL VECTOR ELECTROCARDIOGRAPHY. By Robert P. Grant, M.D., National Heart Institute, Bethesda, Md.; and E. Harvey Estes, Jr., M.D., U. S. Naval Hospital, Bethesda, Md. 149 pages and 41 figures. Price \$4.50. The Blakiston Company, Philadelphia 5, New York 22, Toronto 2.

The authors are both former members of the faculty of Emory University Medical School and it was at Emory that the first edition of this book was privately published by the University for the use of students, faculty members, and local physicians who were fortunate enough to obtain a copy. It was the reviewer’s good fortune to be able to obtain a copy of this first edition and to take a short course in vectorcardiography given by the authors.

The present edition of the book is on much better paper and the general make-up of the book serves for much easier reading. Much of the former material has been rewritten and clarified and the illustrations redrawn to better illustrate the method.

As the authors state, the application of vector methods to the electrocardiogram is not new, but progress in this field has lagged behind that of “pattern” or empirical methods. From my own limited experience I have found that a combination of vector and “pattern” reading makes for a more secure feeling in the interpretation of the “borderline” electrocardiogram. There is no short cut to the interpretation of the electrocardiogram, but this method is put forth merely as a further aid. The book has much to recommend it to anyone interested in cardiology, be he novice or expert.

EDWARD M. WEST, M.D.

DIABETES MELLITUS—Principles and Treatment: By Garfield G. Duncan, M.D., Clinical Professor of Medicine, Jefferson Medical College; Director of Medical Division, Pennsylvania Hospital and the Benjamin Franklin Clinic, Philadelphia. 289 pages with 31 figures and 40 tables. Philadelphia and London: W. B. Saunders Company, 1951. Price \$5.75.

This new book on the principles and treatment of diabetes mellitus by Dr. Duncan, who is Clinical Professor of Medicine at Jefferson Medical College, Philadelphia, and one of the outstanding authorities on metabolic diseases in the United States, is a most desired addition to any physician's library.

The book is very readable, and the management charts are well organized. The use of newer types of therapy such as NPH insulin and the correction of hormonal imbalance in pregnant females who are severe diabetics is discussed in detail. The use of the simplified Food Exchange System recently adopted by the American Diabetes Association adds much to the clarity of diet in the diabetic patient.

EDGAR D. SHANKS, JR., M.D.

A TEXTBOOK OF MEDICINE—Edited by: Russell L. Cecil, M.D., Sc.D., Professor of Clinical Medicine, Emeritus, Cornell University, New York. Robert F. Loeb, M.D., Bard Professor of Medicine, Columbia University, New York. Associate Editors: Alexander B. Gutman, M.D., Professor of Medicine, Columbia University, New York; Walsh McDermott, M.D., Associate Professor of Medicine, Cornell University, New York; Harold G. Wolff, M.D., Associate Professor of Medicine (Neur.), Cornell University, N. Y. New, 8th edition. 1627 pages, 204 figures, 40 tables. Philadelphia and London: W. B. Saunders Co., 1951. Price \$12.00.

The eighth edition of this standard textbook of medicine continues in excellence and is most deserving in being probably the most widely used medical text in this country both by students of medicine and individual physicians.

As compared with the seventh edition numerous changes and additions have been made. Some twenty new disease subjects are discussed and the retirement or death of a number of former contributors has necessitated the preparation of eighty-two new treatises on subjects previously covered. In spite of these numerous changes the total length of this edition has been shortened by 136 pages.

This book is recommended both to physicians and students alike without reservation.

EDGAR D. SHANKS, JR., M.D.

DIFFERENTIAL DIAGNOSIS OF INTERNAL DISEASES. By Julius Bauer, M.D., F.A.P.C., published by Grune & Stratton, New York, 1950; 866 pages. Price \$12.00.

This most recent book of Dr. Bauer, who is Clinical Professor of Medicine at the College of Medical Evangelists, Los Angeles, is composed of two main sections. Under the first section are discussed by chapters symptoms referable to and the differential diagnosis of headache, chest pain, abdominal pain, backache, pain in the extremities, disorders of general feeling, disorders of consciousness, vertigo, nausea and vomiting, paralysis, incoordination and involuntary movements, cough and dyspnea, diarrhea and constipation and hemorrhages. The second section of the book is divided into chapters referable to leading signs and includes the general appearance, hyperthermia, fever, and infectious diseases, the respiratory system, the cardiovascular system, the digestive system, the hemopoietic system, the uropoietic system and glycosuria.

Parts of chapters concerned with the infectious diseases and the electrocardiogram were written by the author's son, Dr. Franz K. Bauer.

The book contains an extensive bibliography and an author's index as well as a subject index.

It is recommended to physicians interested in the special problems of differential diagnosis in internal medicine.

EDGAR D. SHANKS, JR., M.D.

WASHINGTON NEWS

Recent statements of the President. The reaction varied considerably to Mr. Truman's statements on the occasion of the dedication of the 500-bed Clinical Center for Medical and Cancer Research at Bethesda in late June at which time he stated:

"I want to make it clear, however, that I am not clinging to any particular plan. What I want is a good workable plan that will enable all Americans to pay for the medical care they need, and I will say here and now that if the people who have been blocking health insurance for five years will come up with a better proposal or even one that is almost as good, I will go along with them. I want to get the job done, and I am not concerned in the slightest with pride of authorship."

AMA President, Dr. John W. Cline replied stating:

"If the President is sincere in that statement, as I assume he is, the controversy of which he spoke will quickly disappear, because a better program already is available and is functioning admirably—the American medical system, which has made this the healthiest great nation in the world.

"The problem of insurance against the economic hazards of illness is well on its way to orderly solution within the existing framework

of private enterprise. It is unfortunate that the President would belittle the great progress which has been made in the development of our voluntary health insurance system, for nearly half the people of this country already have some form of prepaid medical care as a result of it, and within the next few years this problem will be largely resolved. Both the benefits and the coverage are expanding rapidly under the voluntary medical care programs.

"We will welcome President Truman's help and support if he and the members of his administration will aid in the development of the voluntary health insurance system. That is the American way to meet this problem and the American people have demonstrated clearly that they prefer it to any system of government controlled medical care."

Some observers were disheartened over the entire statement feeling that Dr. Cline failed to recognize the spirit of the President's message, and did not note that the President devoted over half of his message to cheerful acknowledgment of health gains. Everyone noted the significant fact that the ceremony was not attended by any AMA leaders, even though all had been invited. Would it not be expedient to stand as close to the administration as possible and attempt to quietly direct its thinking and action back into the straight and narrow path?

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LABOR ASSOCIATED WITH CONTRACTED PELVIS

ALVA H. FAULKNER, M.D., BETTY ANN BROOKS, M.D., and RICHARD TORPIN, M.D., *Augusta*

INTRODUCTION

The management of labor in patients with contracted pelvis has long been a subject of controversy and the cause of much worry and travail to the obstetrician. It is the purpose of this paper to present a statistical study of a series of these cases which were encountered at the University Hospital during the twelve year period between 1938 and 1950.

MATERIAL AND METHODS

The criterion for determining pelvic contractions was based upon the grid method of roentgenographic pelvimetry described in 1938 by Torpin.¹⁰ This method is a modification of Thoms' technic.⁸ Since 1938, it has been the policy at the University Hospital to obtain routine pelvic measurements on every staff primipara and on any multipara who had had a previous prolonged or difficult labor. During the years incorporated in this study, 3406 roentgenographic inlet grid films in the gravid female were made. These films were reviewed early in the course of this study and three measurements were obtained:

1. Anteroposterior diameter of the pelvic inlet.
2. Transverse diameter of the pelvic inlet.
3. Transverse diameter of the mid-pelvis (or the distance between the ischial spines).

The third measurement was obtained by counting the centimeter markings between the tips of the ischial spines and adding 10 per cent for the correction inasmuch as the level of the ischial spines is located on an average of 54 mm. below the level of the

obstetric pelvic inlet in which plane the grid is presumed to lie. Extensive study in regard to this determination had been reported and is now in print.²⁰ In making this calculation the tube film distance should be 30 inches. However, the error is not greatly significant if the distance should be as much as 36 inches.

Of the 3406 films thus reviewed, 287 (or 8.43 per cent) were found to have one or more of these three diameters measuring 9 cm. or less. Of these 287 cases of contracted pelvis selected, only 181 were found to have records which contained adequate data for analysis. Fifteen cases in this number had had two or more labors so that the total number of labors studied is 202.

In the course of the study, it became apparent that contraction at the level of the pelvic inlet was more significant than mid-plane contraction; therefore, the total of 202 labors in contracted pelvis were classified according to the type of pelvic contraction. In the pelvis with inlet contraction (anteroposterior diameter of 9.0 cm. or less) 77 labors were studied; in those with mid-plane contraction, (distance between the ischial spines of 9.0 cm. or less) 115 labors were studied, and in those generally contracted (two or more diameters of 9.0 cm. or less) 10 labors were studied. The distribution of cases according to type of pelvic contraction is shown in Table 1.

In the management of cases of contracted pelvis at this institution, it has been the rule to give such patients a test of labor if the anteroposterior diameter of the inlet measured 9 cm. or more.¹⁸ Only a very small percentage of patients were not allowed a

From Department of Obstetrics and Gynecology, Medical College of Georgia, Augusta.

Read before the Medical Association in annual session, Augusta, April 20, 1951.

Table 1. TYPE OF PELVIC CONTRACTION

Contracted Inlet		Contracted Mid-pelvis		Generally Contracted		Totals	
No.	%	No.	%	No.	%	No.	%
77	38.1	115	56.9	10	5.0	202	100.0

Table 2. RACE

Race	Contracted Inlet		Contracted Mid-Pelvis		Generally Contracted		Totals	
	No.	%	No.	%	No.	%	No.	%
Colored	60	77.9	75	65.2	6	60.0	141	69.8
White	17	22.1	40	34.8	4	40.0	61	30.2
Totals	77	100.0	115	100.0	10	100.0	202	100.0

Table 3. AGE AND PARITY

Table 3-a. CONTRACTED PELVIC INLET

Age in Years	Primiparae		Multiparae		Totals	
	No.	%	No.	%	No.	%
14-20	26	55.3	2	6.7	28	36.4
20-30	18	38.3	11	36.6	29	37.6
30-40	3	6.4	14	46.7	17	22.1
40 and over	0	0	3	10.0	3	3.9
Totals	47	100.0	30	100.0	77	100.0

test of labor. One case with an anteroposterior diameter of the inlet of 9.0 cm. and a history of classical cesarean section in her two previous pregnancies, was not allowed a test of labor. Several cases with anteroposterior diameters of the inlet of less than 9.0 cm. were admitted after a variable number of hours of labor. These would have had cesarean section according to the rule at onset of labor had they been seen at that time. Several additional cases who fell in the neglected class would not have been subjected to a test of labor had they been in the hospital at the time of onset of labor. These were the patients who had had a long labor before admission and were referred to the hospital because of prolonged labor with no progress and often after unsuccessful attempts at delivery.

In the cases subjected to a test of labor, special efforts were made to prevent exhaustion so that the patients in whom the test failed would be in good condition for any

operative procedure deemed necessary. Supportive therapy included adequate fluids, nourishment and vitamins parenterally; and blood, oxygen, morphine and magnesium sulfate whenever indicated.

The factors tabulated in this study were: type of pelvic contraction, race, age and parity, pelvic classification, length of first and second stages of labor, type of delivery, weight of the baby, condition of the baby at birth and condition later, maternal morbidity, complications, and maternal mortality.

Case histories are presented in the cases of stillbirths, neonatal deaths and maternal deaths.

DISCUSSION

The distribution of patients according to race is shown in Table 2. Of the total 202 labors studied 141 or 69.8 per cent were Negro and 61 or 30.2 per cent were white.

Age and Parity: Tables 3a., b., and c. give the distribution according to age and

Table 3-b. MID-PELVIC CONTRACTION

Age	Primiparae		Multiparae		Totals	
	No.	%	No.	%	No.	%
13-20	50	55.5	1	4.0	51	44.3
20-30	33	36.7	13	52.0	46	40.0
30-40	7	7.8	11	44.0	18	15.7
40 and over	0	0	0	0	0	0
Totals	90	100.0	25	100.0	115	100.0

Table 3-c. GENERALLY CONTRACTED PELVES

Age	Primiparae		Multiparae		Totals	
	No.	%	No.	%	No.	%
14-20	4	57.1	1	33.3	5	50.0
20-30	2	28.6	2	66.7	4	40.0
30-40	1	14.3	0	0	1	10.0
40 and over	0	0	0	0	0	0
Totals	7	100.0	3	100.0	10	100.0

Table 4. CLASSIFICATION OF PELVES

Type	Contracted Inlet		Contracted Mid-Pelvis		Generally Contracted		Totals	
	No.	%	No.	%	No.	%	No.	%
Gynecoid	41	53.0	57	49.5	9	90.0	107	53.2
Anthropoid	0	0	50	43.5	0	0	50	24.9
Platypelloid	33	43.0	1	0.9	0	0	34	16.9
Android	3	4.0	7	6.1	0	0	10	5.0
Totals	77	100.0	115	100.0	9*	90*	201*	100.0

*One pelvis (10 per cent) was malformed and could not be classified.

parity. In the contracted inlet series of 77 cases (Table 3a.), 47 or 61.0 per cent were primiparae and 30 or 39.0 per cent were multiparae. In the age group of 14-20 years, there were 28 cases or 36.4 per cent; in the 20-30 age group there were 29 or 37.6 per cent; in the 30-40 age group there were 17 or 22.1 per cent and in the 40 and over group there were three cases or 3.9 per cent. A total then of 74.0 per cent were under 30 years of age.

In the contracted mid-pelvis series of 115 cases (Table 3 b.) 90 cases or 78.3 per cent were primiparae and 25 or 21.7 per cent were multiparae. 51 or 44.3 per cent fell in the age group of 13-20 years; 46 or 40.0 per cent in the 20-30 years; 18 or 15.7 per cent in the 30-40 age group. There were

no cases of 40 years of age or over in this series.

In the generally contracted pelvis (Table 3 c.) 7 or 70.0 per cent were primiparae; and 3 or 30.0 per cent were multiparae. 5 or 50.0 per cent of this number were between 14 and 20 years of age; 4 or 40.0 per cent between 20 and 30 years; and 1 or 10 per cent between 30 and 40.

Classification of Pelves: Table 4. The pelves in this study were classified according to the classification of Caldwell, Moloy and D'Esopo.⁵ In the contracted inlet series of 77 cases, 41 or 53 per cent were of gynecoid type; 3 or 4.0 per cent were of android type; 33 or 43.0 per cent were platypelloid in type.

In the contracted mid-pelvis series of 115

Table 5-a. LENGTH OF 1ST STAGE LABOR

Length of 1st Stage Hours	Contracted Inlet		Contracted Mid-Pelvis		Generally Contracted		Totals	
	No.	%	No.	%	No.	%	No.	%
1-20	38	60.3	61	62.2	7	77.8	106	62.4
20-40	13	20.7	24	24.5	1	11.1	38	22.3
40-60	6	9.5	8	8.2	1	11.1	15	8.8
60 & over	6	9.5	5	5.1	0	0	11	6.5
Totals	63	100.0	98	100.0	9	100.0	170	100.0

Table 5-b. LENGTH OF 2nd STAGE OF LABOR

Length of 2nd Stage Hours	Contracted Inlet		Contracted Mid-Pelvis		Generally Contracted		Totals	
	No.	%	No.	%	No.	%	No.	%
0-2	41	65.1	61	62.2	5	55.6	107	62.9
2-4	8	12.7	20	20.4	1	11.1	29	17.1
4-6	3	4.8	9	9.2	0	0	12	7.0
6 and over	5	7.9	4	4.1	1	11.1	10	5.9
Not recorded	0	0	1	1.0	0	0	1	0.6
No 2nd Stage	6	9.5	3	3.1	2	22.2	11	6.5
Totals	63	100.0	98	100.0	9	100.0	170	100.0

cases, 57 or 49.5 per cent were gynecoid; 50 or 43.5 per cent were anthropoid; 7 or 6.1 per cent were android; and 1 or 0.9 per cent was platypelloid in type. In the generally contracted series, 9 or 90 per cent were gynecoid in type. One case could not be classified because of gross malformation of the pelvic inlet. Of the total of 201 pelves in the entire study, 53.2 per cent were gynecoid in type; 24.9 per cent were anthropoid; 5 per cent were android and 16.9 per cent were platypelloid.

Length of Labor in Stages: Tables 5-a and b. In 170 cases sufficient data was available to tabulate length of labor in the first and second stages. In the contracted inlet series of 63 cases (Table 5-a.) 38 or 60.3 per cent had a first stage of from 1-20 hours; 13 or 20.7 per cent had a first stage of from 20-40 hours; 6 or 9.5 per cent had a first stage of from 40-60 hours; and 6 or 9.5 per cent had a first stage lasting over 60 hours.

In the contracted mid-pelvis series of 98 cases, 61 or 62.2 per cent had a first stage lasting from 1-20 hours; 24 or 24.5 per cent had a first stage of 20-40 hours; 8 or 8.2 per cent had a first stage of 40-60 hours;

and 5 or 5.1 per cent had a first stage of over 60 hours. In the generally contracted series of nine cases, 7 or 77.8 per cent had a first stage of from 1-20 hours; 1 or 11.1 per cent had a first stage of from 20-40 hours; and 1 or 11.1 per cent had a first stage of between 40-60 hours.

Of the total number of 170 cases, 106 or 62.4 per cent reached full dilatation in 1-20 hours; 38 or 22.3 per cent in 20-40 hours; 15 or 8.8 per cent in 40-60 hours and 11 or 6.5 per cent had a first stage of 60 hours or over.

Table 5-b. shows tabulation on length of the second stage of labor: In the contracted inlet series of 63 cases, the second stage was terminated in under two hours in 41 or 65.1 per cent; in 2-4 hours in 8 or 12.7 per cent; in 4-6 hours in 3 or 4.8 per cent; in over six hours in 5 or 7.9 per cent; 6 or 9.5 per cent in this series had no second stage because operative delivery was performed as soon as full dilatation was accomplished.

In the contracted mid-pelvis series of 98 cases: second stage was terminated in less than two hours in 61 or 62.2 per cent; in 2-4 hours in 20 or 20.4 per cent; in 4-6 hours in

Table 6. TOTAL LENGTH OF 1ST AND 2ND STAGES

Hours	Contracted Inlet		Contracted Mid-Pelvis		Generally Contracted		Totals	
	No.	%	No.	%	No.	%	No.	%
1-20	43	58.9	64	58.2	6	60.0	113	58.6
20-40	15	20.6	34	30.9	2	20.0	51	26.4
40-60	7	9.6	7	6.4	2	20.0	16	8.3
60 and over	8	10.9	5	4.5	0	0	13	6.7
Totals	73	100.0	110	100.0	10	100.0	193*	100.0

* Length of labor not recorded in nine cases.

Table 7. TYPE DELIVERY

Type Delivery	Contracted Inlet		Contracted Mid-Pelvis		Generally Contracted		Totals	
	No.	%	No.	%	No.	%	No.	%
Spontaneous	59	75.6	101	87.8	5	50.0	165	81.3
Forceps	6	7.7	10	8.7	0	0	16	7.9
Cesarean	7	9.0	4	3.5	3	30.0	14	7.0
Breech Extraction	2	2.6	0	0	1	10.0	3	1.4
Version and Extraction	1	1.3	0	0	0	0	1	0.5
Craniotomy	3	3.8	0	0	1	10.0	4	1.9
Totals	78*	100.0	115	100.0	10	100.0	203*	100.0

* One set of twins.

9 or 9.2 per cent: in over six hours in 4 or 4.1 per cent; 3 cases or 3.1 per cent were delivered as soon as second stage was reached. In one case the length of second stage was not recorded.

In the generally contracted series of 9: 5 or 55.6 per cent terminated the second stage in less than two hours; 1 or 11.1 per cent delivered after a second stage of 2-4 hours and 1 or 11.1 per cent had a second stage of over six hours. Two cases or 22.2 per cent had no second stage because of delivery at the time of full dilatation. Of the total of 170 cases, 107 or 62.9 per cent terminated the second stage in less than two hours, 29 or 17.1 per cent had a second stage of 2-4 hours; 12 or 7.0 per cent had a second stage of 4-6 hours; 10 or 5.9 per cent had a second stage of over six hours; 11 or 6.5 per cent of the total number had no second stage and in one case or 0.6 per cent there was no record of second stage.

Length of First and Second Stages of Labor: Table 6 shows the length of first and

second stages combined in 193 cases. In nine labors of the entire series the length of labor was not recorded. The table shows numbers and percentages for the contracted inlet series, contracted mid-pelvis series and the generally contracted series. The percentage of labors in each series in which delivery occurred in 1-20 hours varied from 58.2 per cent to 60.0 per cent. In the contracted inlet series, 15 or 20.6 per cent delivered within 20-40 hours; in the contracted mid-pelvis series 10.9 per cent were in labor over 40 hours; and in the generally contracted pelvis 20 per cent were in labor over 40 hours.

Of the total 193 labors, 113 or 58.6 per cent had labors which terminated in less than 20 hours; 51 or 26.4 per cent in 20-40 hours; 16 or 8.3 per cent in 40-60 hours and 13 or 6.7 per cent had labors of 60 hours or over.

Type of Delivery: The type of delivery in 203 cases is shown in Table 7. In the contracted inlet series of 78 deliveries 59 or

Table 8. WEIGHTS.

	Contracted Inlet	Contracted Mid-Pelvis	Generally Contracted	Entire Series
Average Weight	6.92 lbs. or 3138.9 Gm.	6.79 lbs. or 3079.9 Gm.	6.37 lbs. or 2889.4 Gm.	6.69 lbs. or 3034.6 Gm.

Table 9. CONDITION OF BABY AT BIRTH

Condition	Contracted Inlet		Contracted Mid-Pelvis		Generally Contracted		Totals	
	No.	%	No.	%	No.	%	No.	%
Good	61	78.2	94	81.8	5	50	160	78.8
Fair	1	1.3	2	1.7	0	0	3	1.5
Poor	7	9.0	13	11.3	3	30	23	11.3
Stillbirths	9	11.5	6	5.2	2	20	17	8.4
Totals	78*	100.0	115	100.0	10	100.0	203*	100.0

* One set of twins.

75.6 per cent were spontaneous; 6 or 7.7 per cent were forceps; 7 or 9 per cent were delivered by cesarean; 2 or 2.6 per cent by breech extraction; 1 or 1.3 per cent by version and extraction; and 3 or 3.8 per cent by craniotomy. In the contracted mid-pelvis series of 115: 101 or 87.8 per cent delivered spontaneously; 10 or 8.7 per cent were forceps deliveries; and 4 or 3.5 per cent were delivered by cesarean.

In the generally contracted series of 10: only 5 or 50.0 per cent delivered spontaneously; 3 or 30 per cent by cesarean; 1 or 10 per cent by breech extraction; and 1 or 10 per cent by craniotomy. Of the total of 203 infants delivered; 165 or 81.3 were spontaneous; 16 or 7.9 per cent by forceps; 14 or 7 per cent by cesarean; 3 or 1.4 per cent by breech extraction; and 4 or 1.9 per cent by craniotomy; 1 or 0.5 per cent by version and extraction.

Weight of Infants: The average birth weight of infants in each series and the average for the entire series are recorded in Table 8. No previable infants were included in this study. Weights varied from 1871.1 Gm. to 4507.7 Gm. with an average birth weight of 3034 Gm. for the entire series of 203 infants.

Condition of Baby: The condition of the infants at birth is tabulated in table 9. The condition of the infant was considered good if respirations were established promptly and

maintained. Fair and poor infants include those with delayed respirations, cyanosis, or any other abnormality which would render the condition fair or poor. Many of these infants were resuscitated by the Torpin method of endotracheal insufflation.¹²

There is a total of 203 infants. In the contracted inlet series of 78 cases, the condition of 61 or 78.2 per cent was good; 1 or 1.3 per cent was fair; 7 or 9.0 per cent poor; there were 9 or 11.5 per cent stillbirths. In the contracted mid-pelvis series of 115 cases 94 or 81.8 per cent were good; 2 or 1.7 per cent were fair; 13 or 11.3 per cent were poor; and 6 or 5.2 per cent were stillborn.

In the generally contracted series of 10 cases: 5 or 50 per cent were good; 3 or 30 per cent were poor and 2 or 20 per cent were stillborn. Of the total 203 infants, 160 or 78.8 per cent were in good condition at birth; 3 or 1.5 per cent were in fair condition; 23 or 11.3 per cent were in poor condition; and 17 or 8.4 per cent were stillborn.

The study of the condition of the infants after birth was limited to their period of hospitalization in the neonatal period. Of the 186 live births in the entire series 3 or 1.6 per cent succumbed in the neonatal period.

The 17 stillbirths plus the three neonatal deaths in the entire series of 203 gives an uncorrected fetal loss of 9.85 per cent. A brief

history of labor in the cases which eventuated in delivery of stillbirths follows:

CASE REPORTS

Case 1. L. B., aged 15, colored primipara, anteroposterior diameter of the inlet of 9 cm., admitted with a tetanic uterus and an anemia of 6 Gm., not in labor. Admitting diagnosis was premature separation of the placenta. No fetal heart sounds were heard on the day before delivery. After seven hours and 50 minutes of labor she delivered spontaneously of an 8 pounds 3 ounce macerated female infant. Examination of the placenta verified the diagnosis. Fetal death was considered antepartum in this case.

Case 2. J. C., aged 23, colored primipara, with an anteroposterior diameter of the inlet of 9 cm., was admitted in labor with a complication of preeclampsia. After 57½ hours of labor the F.H.T. were not audible and after 71 hours and 15 minutes of first stage the patient was delivered by craniotomy of a 5 pound 14 ounce female. Fetal death was intrapartum. Complications were preeclampsia, anemia and prolonged labor.

Case 3. A. C., aged 20, colored primipara was admitted in labor with an anemia of 7 Gm., anteroposterior diameter of the inlet was 9 cm., Labor was prolonged. Forceps were attempted and unsuccessful, the fetus dying; she was delivered by craniotomy of a male infant after 86 hours of labor. Fetal death was intrapartum and labor was complicated by anemia and disproportion.

Case 4. S. H., aged 24, colored primipara, an achondroplastic type dwarf, anteroposterior diameter of the inlet of 9 cm., was admitted after 40 hours of labor and after having had three or more convulsions. On admission T-100°F, P-120, BP-180/100, F.H.T. were slow, irregular and of poor quality. She was delivered by craniotomy of an 8 pound 6 ounce infant a few hours after admission and after F.H.T. ceased. Fetal death was intrapartum. She was classed as a neglected case and complicated by intrapartum eclampsia.

Case 5. C. H., aged 27, colored primipara.* First stage of labor lasted 14 hours and 30 minutes. After 4 hours and 40 minutes of second stage, forceps were attempted but unsuccessful. Internal podalic version and extraction was done with difficulty. F.H.T. had been good 40 minutes before delivery. She was delivered of a male infant weighing 8 pounds and 7 ounces. Fetal death was intrapartum and resulted apparently from trauma during delivery.

Case 6. L.M.J., aged 31, colored female, para 6, was admitted with a diagnosis of preeclampsia and premature separation of the placenta, anteroposterior diameter of inlet was 8.6 cm. B.P. 170/100 on admission. F.H.T. were not heard.

After 15 hours and 40 minutes of labor she was delivered of a 9 pound 15 ounce macerated female by breech extraction. Fetal death was antepartum and labor complicated by preeclampsia and premature separation of the placenta.

Case 7. E.M., aged 21, colored primipara was admitted as an eclamptic in labor with sepsis. On admission T-102°F, P-128, B.P. 225/140. She had reportedly been in labor for five days. On admission cervix was 5 cm. dilated. F.H.T. were recorded as 140. Fifteen hours after admission she delivered spontaneously a 7 pound 2 ounce male infant. Fetal death was considered intrapartum. This was a neglected case complicated by intrapartum eclampsia, prolonged labor and sepsis.

Case 8. H. P., aged 30, colored female, para 2, admitted in congestive heart failure. Anteroposterior diameter of the inlet of 8.5 cm. F.H.T. were good before labor. After a labor of 76 hours, she delivered spontaneously an 8 pound 4 ounce female. F.H.T. not recorded during labor, and time of fetal death is unknown, presumably intrapartum. This case was complicated by cardiac decompensation and prolonged labor.

Case 9. S.R., aged 20, colored female, para 3, 7½ months pregnant, admitted in shock with BP 90/60 and painless vaginal bleeding. Anteroposterior diameter of the inlet was 8.5 cm. No F.H.T. could be heard. Diagnosis was placenta previa with breech presentation. Membranes were ruptured after blood transfusions in an effort to induce labor and control bleeding. A Voorhees bag was inserted as soon as the cervix began to dilate and after 11 hours and 50 minutes of labor she was delivered of a 5 pound premature male by breech extraction. Fetal death was considered antepartum. This was a premature labor complicated by placenta previa marginalis, secondary anemia and breech presentation.

Case 10. P.D., aged 18, colored primipara, admitted in labor with eclampsia. Transverse diameter of the mid-pelvis was 8.14 cm. She had a normal first stage lasting 13 hours and 40 minutes. F.H.T. remained 180 throughout labor. She had a prolonged second stage and after 25 hours and 40 minutes of total labor, a mid-forceps delivery was done with delivery of a 7 pound 3 ounce male. The patient had six convulsions during labor. Fetal death was intrapartum.

Case 11. M.E., aged 23, colored primipara, who on admission had T-101°F. and P-120. History revealed that "several" vaginal examinations had been done by a midwife before admission. Transverse diameter of the mid-pelvis was 8.8 cm. First stage of labor lasted 21 hours; second stage, 4 hours and 8 minutes. She delivered spontaneously a 9 pound 12 ounce male. Fetal death was intrapartum in the second stage. Labor complicated by sepsis.

*Anteroposterior diameter of the inlet of 9 cm.

Table 10. MATERNAL MORBIDITY

Morbidity	Contracted Inlet		Contracted Mid-Pelvis		Generally Contracted		Totals	
	No.	%	No.	%	No.	%	No.	%
Plus	22	28.5	19	16.6	3	30.0	44	21.8
Minus	55	71.5	93	80.9	7	70.0	155	76.7
Not Recorded	0	0	3	2.5	0	0	3	1.5
Totals	77	100.0	115	100.0	10	100.0	202	100.0

Case 12. P.L., aged 17, white primipara, admitted in labor.* F.H.T. were not audible on admission and were not heard at any time thereafter. After 29 hours of labor in hospital plus an undetermined number of hours before admission the cervix was 6 cm. dilated and head unengaged. Cesarean section was done at this time because the head was too high for craniotomy. The fetus weighed 6 pounds 5 ounces and was macerated. Time of fetal death was thought to be antepartum.

Case 13. C. S., aged 21, colored primipara; labor was prolonged and complicated by preeclampsia. Transverse diameter of mid-pelvis was 8.8 cm. F.H.T. were good on admission but were not heard in the nine hours before delivery. After a first stage of 56 hours and 18 minutes, the cervix was fully dilated and mid-forceps delivery was done. Fetal death was intrapartum.

Case 14. A.H.T., aged 15, colored primipara, admitted in labor with T-103°F. and W.B.C. 22,600.** Membranes had ruptured three days before. F.H.T. were recorded as 170 in first stage and remained rapid; last heard 30 minutes before delivery. The first stage of labor lasted 17 hours; second stage 6 hours and 45 minutes. Delivery was spontaneous after manual rotation of the head from ROP to ROA. The infant, a male, weighed 5 pounds 12 ounces and death was intrapartum. Labor was complicated by sepsis.

Case 15. L.W., aged 19, colored primipara, admitted in labor, length of labor was not recorded. Transverse diameter of the mid-pelvis was 8.8 cm. The cord prolapsed in the course of labor and attempts at reposition were unsuccessful. She delivered a 6 pound male stillborn spontaneously. Fetal death was intrapartum and thought to be caused by prolapse of the cord.

Stillbirths in Generally Contracted Series

Case 16. W.S., aged 17, colored primipara; length of labor unknown. She was in labor an indefinite number of hours before admission and had had five vaginal examinations by midwife and doctor. On admission, temperature was 103°F, she was markedly dehydrated, the bladder was distended to the umbilicus and there was

avulsion of the anterior lip of the cervix. No F.H.T. were audible.*** Craniotomy and cleidotomy were performed and a male weighing 5 pounds and 7 ounces was delivered. Time of fetal death was unknown. This was a neglected case.

Neonatal Deaths

Case 17. M.D., aged 20, colored female, para 4, admitted to hospital because of preeclampsia at eight months. A.P. diameter of the inlet was 9 cm. Labor was induced by artificial rupture of the membranes and after 35 hours and 30 minutes of labor she delivered spontaneously a female weighing 5 pounds and 13 ounces. This infant required suction and insufflation for 15 minutes and lived until the following day. This case was complicated by preeclampsia and premature labor, artificially induced.

Case 18. M.D.J., aged 22, colored female, para 1, with transverse diameter of the mid-pelvis of 8.8 cm., had a normal spontaneous delivery of a male infant weighing 6 pounds 14 ounces. The infant cried once but respirations were never established; resuscitation with Torpin insufflator and endotracheal catheter for 45 minutes until death. Total length of labor was 11 hours and 18 minutes. The labor was uncomplicated.

Case 19. L.M.K., aged 19, white primipara, was delivered of a 7½ month male premature after 11 hours and 55 minutes of labor. The baby was apneic at birth and was insufflated for 75 minutes. The infant died 10 hours after birth.

Maternal Morbidity: The maternal morbidity is tabulated in Table 10. Morbidity was considered present when there was temperature elevation to 100°F. or above on any two of the first 10 days postpartum.

Morbidity was present in 28.5 per cent of cases in the contracted inlet series, in 30 per cent of the generally contracted series and in only 16.6 per cent in the contracted mid-pelvis series. This difference would be expected because of the smaller incidence of operative deliveries in the mid-plane contraction series.

Of the total of 202 labors, 44 or 21.8 per cent had morbidity; 155 or 76.7 per cent

*A.P. 9.4 cm., Trans. 11 cm., Spines 8.25 cm.

**A.P. 11.75 cm., Trans. 10.0 cm., Spines 8.8 cm.

***A.P. 8.0 cm., Trans 10.0 cm., Spines 8.36 cm.

had no morbidity and in three cases or 1.5 per cent presence or absence of morbidity was not recorded.

The most frequent causes of morbidity in this study were urinary tract infection and genital tract infection. In many cases the fever was unexplained.

Table 11.

Complications	Contracted Inlet	Contracted Mid-Pelvis	Generally Contracted	TOTALS
Preeclampsia	13	18	1	32
Anemia	7	9	0	16
Eclampsia	5	6	0	11
Premature Labor	5	6	0	11
Fever on Admission	2	2	2	6
Premature Separation	2	0	1	3
Prolapsed Cord	0	1	1	2
Lacerated Cervix	2	0	0	2
Vesico-Vaginal Fistula	0	1	1	2
Postpartum Hemorrhage	1	1	0	2
Congestive Heart Failure	2	0	0	2
Diabetes	2	0	0	2
Placenta Previa	1	0	0	1
TOTALS	42	44	6	92

Complications: Complications incidental to pregnancy and delivery are shown in table 11. They are listed in order of frequency; those encountered most often in this study were preeclampsia, anemia, eclampsia, and premature labor. Six cases had fever on admission. Post-partum hemorrhage was noted in two cases, vesico-vaginal fistulae complicated two cases; one developed in a neglected case who had been in labor for five days before admission and on admission was infected and had an avulsion of the anterior lip of the cervix. It was not known whether this was caused by pressure necrosis or attempts at delivery. Craniotomy and cleidotomy were done on a macerated fetus and the fistula was successfully repaired five months post-partum; the second followed a mid-forceps delivery in a patient with a nar-

row mid-pelvis (8.8 cm.) who sustained a laceration of the anterior vaginal wall. The complications of premature separation of the placenta, placenta previa, and prolapsed cord accounted for antepartum and intrapartum deaths of five infants in the entire series. The complications of congestive heart failure and diabetes occurred in the same patient in two labors and contributed at least to her death though the immediate cause of death was unknown. The complication of cervical laceration occurred in two cases; in one, delivery was by version and extraction; in the other delivery was accomplished by craniotomy and cleidotomy in a neglected case.

Maternal Mortality: Mortality is recorded in Table 12 for each series and for the entire study. There were two maternal deaths in the 202 labors studied, giving a mortality of 0.99 per cent. Both deaths occurred in patients with a contracted pelvic inlet. Their case histories are presented:

Case 20. S.H., aged 24, G¹P⁰, achondroplastic-type dwarf with ankylosis of the cervical vertebrae, ankylosis of the left hip and atrophy of the left leg. This patient was admitted with a history of having been in labor for approximately 40 hours and having had three or more convulsions. She had had no prenatal care. On admission T-100.2°F., P-120 and BP 180/100; fetal heart sounds were slow, irregular, and of poor quality. X-ray of the pelvis revealed an anteroposterior diameter of the inlet of 9.0 cm., adequate transverse diameter of the inlet and adequate mid-pelvis. Section was thought to be contraindicated because of the history of long labor, the patient's condition on admission, and the poor prognosis for the fetus.* Craniotomy and cleidotomy were done when the patient was prepared. During the procedure the BP dropped to 40/?. The cervix was found to be lacerated; the cervix and perineum were repaired and the uterus was packed. The patient received two transfusions of 500 cc. each and nasal O₂ constantly after delivery. On the first postpartum day BP was recorded as 100/60. Her subsequent postpartum course was characterized by a normal BP of 110/70 to 120/90, a persistently rapid

*When F.H.T. were no longer heard.

Table 12. MATERNAL MORTALITY

	Contracted Inlet	Contracted Mid-Pelvis	Generally Contracted	Entire Study
Maternal Mortality	2 (2.59%)	0	0	2 (0.99%)

pulse, septic temperature, leukocytosis to 26,000, a moderately distended abdomen, lower abdominal tenderness and a foul vaginal discharge. She expired on the sixth postpartum day. Autopsy was performed and finding included:

1. Laceration of cervix uteri.
2. Necrobiosis of liver.
3. Acute toxic nephritis.
4. Infarction of posterior lobe of pituitary.
5. Pulmonary congestion and edema.
6. Quiescent pulmonary tuberculosis, bilateral.
7. Fibrous pleural adhesions.
8. Adhesive pericarditis.

Case 21. H.P., aged 35, Gravida 6, Para 5 was admitted to the hospital in July of 1940 in hard labor. Her admitting diagnoses included: (1) active labor, (2) congestive heart failure, (3) preeclampsia, and (4) diabetes. BP was 220/100, blood sugar 300 plus mg. per cent, urine showed 4 plus albumin and 4 plus sugar. She had marked edema of the vulva. A previous record revealed that she had congestive heart failure as early as 1935 at which time she delivered spontaneously an 8 pound 4 ounce baby. A diagnosis of diabetes had been established in 1937. Her pelvic measurements were anteroposterior 8.5 cm.; trans.: 13.0 cm.; and spines: 11.55 cm. Past obstetrical history revealed she had had five spontaneous deliveries so she was given a test of labor. After 20 hours the cervix was 6 cm. dilated and the head still unengaged. Cesarean section was performed under cyclopropane anesthesia and a 9 pound 7 ounce baby was delivered which required resuscitation but whose condition was considered good after respirations became established. The patient apparently withstood the procedure fairly well and reacted. Twelve hours postoperatively respirations ceased suddenly and permission for autopsy was not obtained.

SUMMARY

A statistical study is presented of 202 labors in patients with contracted pelvis. Pelvic contraction was determined in each case by the inlet grid method of pelvimetry. The cases were classified for study into three groups according to the type of pelvic contraction which existed:

1. Contracted inlet, 38.1 per cent of cases.
2. Contracted mid-pelvis, 56.9 per cent of cases.
3. Generally contracted pelvis, 5 per cent of cases.

The usual management of these cases including test of labor and supportive therapy has been discussed.

Tabulations on age and parity revealed that in the contracted inlet series 61 per

cent were primiparae, 39 per cent multiparae, 74 per cent of cases in this series were under 30 years of age, and 96.1 per cent were under 40. In the contracted mid-pelvis series 78.3 per cent were primiparae; 84.3 per cent were under 30 years of age and no case over 40 years of age. The multiparae in each series fell into a higher age group than the primiparae. The pelvis were classified according to the classification of Caldwell, Moloy and D'Esopo.⁵ 53.2 per cent were gynecoid; 24.9 per cent anthropoid; 5 per cent android; and 16.9 per cent platypelloid. As was expected 43 per cent of cases with a contracted inlet were platypelloid in type while only 0.9 per cent and none were platypelloid in the contracted mid-pelvis and generally contracted series. Also, 43.5 per cent of cases in the contracted mid-pelvis series were anthropoid in type while no pelvis in the other 2 series were so classified.

Length of the first stage of labor was under 20 hours in 62.4 per cent of cases and under 40 hours in 84.7 per cent. Length of the second stage of labor was less than two hours in 62.9 per cent of cases and less than four hours in 80.0 per cent. 6.5 per cent of these were delivered as soon as the cervix became fully dilated and were tabulated as "no second stage". In the contracted mid-pelvis series, 33.7 per cent had prolonged second stage and in the generally contracted series 22.2 per cent had a prolonged second stage. The total length of the first and second stages was less than 20 hours in 58.6 per cent of cases.

As to the type of delivery, 81.3 per cent of the cases in the entire study delivered spontaneously; 7.9 per cent by forceps; 7.0 per cent by cesarean; 1.4 per cent by breech extraction; 0.5 per cent by version and extraction; and 1.9 per cent by craniotomy. It was found that 87.8 per cent of cases in the mid-pelvis contraction series delivered spontaneously as compared with 75.6 per cent in the contracted inlet series and 50.0 per cent in the generally contracted group.

The birth weight of infants varied from 1871.1 gm. to 4507.7 gm. with the average weight for all cases being 3034.6 gm. No previsible infants were included in this study.

The condition of the infants at birth was

found to be good in 78.8 per cent of cases; fair in 1.5 per cent; and poor or requiring resuscitation in 11.3 per cent. 8.4 per cent were stillborn. In addition to the stillbirths, three neonatal deaths occurred which gives an uncorrected fetal loss of 9.85 per cent for the entire study. Case histories have been presented in the 17 cases in which the infants were stillborn and in the three cases in which the infants died during the neonatal period. Of the 17 stillbirths in this series, fetal death was antepartum in four cases. Two of these cases were complicated by premature separation of the placenta, a third by placenta previa and premature labor and in the fourth case the cause of antepartum death of the fetus was unknown. Of the 13 cases remaining in which fetal death was considered intrapartum, five were classified as neglected cases on admission. In addition, three of these cases were complicated by eclampsia, two by prolapse of the cord, two by preeclampsia and one by cardiac decompensation. Of the three neonatal deaths, one case was complicated by preeclampsia and premature labor, artificially induced; a second case by premature labor alone and a third uncomplicated. The length of labor in two of these cases was under 12 hours.

Excluding the four antepartum deaths in this study gives 13 stillbirths or 6.5 per cent and a corrected figure for total fetal loss of 8.1 per cent. This latter figure includes 13 stillbirths and three neonatal deaths in 199 cases.

Morbidity was present in 21.8 per cent of all cases. In the contracted mid-pelvis series in which the incidence of operative deliveries was lowest, morbidity was present in 16.6 per cent of cases. The most frequent causes of morbidity were found to be urinary tract and genital tract infection.

Complications were listed in order of frequency of occurrence and those most often encountered were preeclampsia, anemia, eclampsia and premature labor.

In the 202 labors studied, there were two maternal deaths, a mortality of 0.99 per cent. Their case histories have been presented. One was a neglected case complicated further by eclampsia. The other who had a cesarean was complicated by conges-

tive heart failure, severe preeclampsia and uncontrolled diabetes.

CONCLUSIONS

1. With accurate x-ray appraisal of the pelvis, a more conservative attitude may be taken in the management of patients in labor: Of 202 labors in patients with contracted pelves, 81.3 per cent delivered spontaneously. Eighty-five per cent of cases had labors of less than 40 hours.

2. Contraction at the level of the inlet seems more significant than mid-plane contraction. In this study of cases with inlet contraction 75.6 per cent delivered spontaneously; while 87.8 per cent of cases with mid-pelvic contraction delivered spontaneously. In the small series of generally contracted pelves, only 50 per cent delivered spontaneously.

3. In cases allowed a test of labor, adequate supportive therapy is imperative. Therapy includes fluids, vitamins, blood, oxygen, morphine and magnesium sulfate.

4. With prolongation of the first or second stage of labor fetal mortality is increased. Of the 13 cases in this study in which fetal death was intrapartum, five cases had a total labor of 40 hours or more and four additional cases had a second stage of four hours or more.

5. Immediate resuscitation by endotracheal insufflation is thought to reduce neonatal mortality. Of 26 apneic infants who required such measures, only three succumbed during the neonatal period.

6. At the present time some of the cases in which the fetus died would be managed by cesarean section of extraperitoneal type. At that time the use of antibiotics, blood, transfusions, etc., was not so advanced. Furthermore, knowledge in regard to the midpelvis was not recognized until subsequent studies (20) made exact measurement possible and from this review of the films, the degree of midpelvic contraction was ascertained and the case histories then reviewed. None of the surviving infants have shown up in the spastic clinics so far as is known, but a detailed study of each child has not yet been made.

THE PROBLEM OF PSYCHIC VERSUS SOMATIC DISEASE

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In recent years the practitioner of medicine in any field has been influenced by the current trend toward emphasis on the effects of psychic factors on organic functions of the body. It is our belief that this is a highly desirable state of affairs and that the service rendered to people who become sick is certainly much better and on a sounder basis if one treats the person as an individual rather than treating the illness. However, in our enthusiasm in dealing with environmental and personality aspects of disease we believe there may be a real danger at times that we will presume too much in our final conclusions as a result of positive environmental or personality factors.

It goes without saying that accurate diagnosis is of fundamental importance in the treatment of any individual. Furthermore, it is apparent that there are limitations of our knowledge and/or technic for the diagnosis of organic disease. Regardless of how diligently we apply ourselves and regardless of how excellent are our supplemental methods of diagnosis, including x-ray and laboratory procedures, it still remains true that we may be unable to give a positive answer to a particular problem. Although the history may strongly suggest a psychic basis for the disorder, such an assumption must be made with caution.

It is our purpose to present cases which illustrate how a clinician's judgment can be influenced by an impressive psychic history.

Case 1: A 63 year old white male was quite well until September of 1949, at which time he began to complain of rather vague abdominal pain, radiating through to the back. He had complete x-rays, including gastrointestinal series, barium enema, cholecystogram and intravenous pyelogram, all of which were negative. His pain became more severe and occurred in attacks, which would last from a few minutes to an hour or so and would recur several times a day. During these attacks he would cry out loudly and would thrash about wildly. He was referred to a com-

petent gastroenterologist in another city in January, 1950, and after a thorough hospital study, the following diagnosis was made: 1. Anxiety state. 2. Spastic bowel syndrome. 3. Malnutrition. This diagnosis was made despite a relatively negative past history which included an excellent work record at 46 years on the same job. His symptoms grew worse and on Feb. 24, 1950, an exploratory laparotomy revealed inoperable carcinoma of the pancreas, while multiple metastases. In this man a diagnosis of functional disease was made largely because of negative physical findings and laboratory studies.

Case 2: This 61 year old lady had been a diabetic for about 15 years. She had always had a number of idiosyncrasies and was very strong in her likes and dislikes. At times she would write notes to her husband telling him of visions she had, and of predictions of the future. On one occasion she attempted suicide. Despite this, she was a respected citizen in her community and was the mother of six outstanding children. In April, 1950, she began to complain of abdominal pain which by June was quite severe. At this time, oddly enough, she repeatedly told her family she had a cancer. All studies were negative and in October she was referred to a physician in a large midwestern city. After another thorough work-up, she and her family were told that her diagnosis was psychoneurosis and it was carefully explained to the family that she complained of more pain than she was actually having in order to gain sympathy. She was transferred to a mental institution and after six electric shock treatments, she developed jaundice. During all of this time she continued to complain bitterly of abdominal pain. An exploratory laparotomy revealed inoperable carcinoma of the pancreas. At least three competent internists and two psychiatrists had been convinced that this woman's pain was not organic.

Case 3: This 33 year old lady began to have episodes of pain in the right cheek in April, 1949, chiefly when nervous or tired. The pain at first lasted for about an hour at a time, but by October was more constant. In January she noticed a gradual loss of vision in the right eye and the pain spread around the right eye, up to the vertex of the skull, down to the ear, and into the right shoulder. Physical examination and neurological examination were entirely negative except for a central scotoma in the right visual field, which strongly suggested a retrobulbar neuritis, and extreme tenderness over the right cheek. A tentative diagnosis of migraine was made.

In delving into her past history it was learned

Read before the Medical Association in annual session, Augusta, April 19, 1951.

that her mother died when the patient was only three. Her father, who was nervous and high-strung, married another woman and would have nothing to do with this child, who was then of necessity reared by an old maid aunt. At the age of sixteen she married and soon had a baby. Her husband began to drink heavily and left her soon after the birth of her second baby. The baby, at the age of six weeks, had an operation for pyloric stenosis and was very ill but the husband refused to pay any of the medical expenses. She married a second time, the husband being described as a "spoiled and immature man who never did a lick of work." They were divorced after two years. She then married a man thirty years her senior. He could not stand the children and would not even allow them to eat at the table with him. He drank heavily and finally ran the wife and children from the house with a shotgun. Following her divorce from him, she married a divorcee with four daughters and the six children all moved in with the newlyweds. She soon became pregnant and was three months pregnant at the time she presented herself for physical examination.

The patient did not respond to the usual treatment for migraine and when she was again referred to a neurologist it was found that she had a mixed tumor of the parotid gland which had invaded the orbit. Complete exenteration of the right orbit had to be performed.

The impressive life experiences of this woman apparently had nothing to do with the pain in her face or her malignancy, but certainly delayed an accurate diagnosis.

Case 4: This 48 year old business man was first seen in May, 1950. He complained of sore throat of two months duration. There had been no fever or constitutional symptoms. He had seen four ENT specialists during the time, none of whom found any evidence of local disease. The right lobe of his thyroid was believed to be slightly large, but was not tender. Physical examination was otherwise negative. A BMR was plus 14 per cent.

It was brought out that he was under considerable financial pressure and felt that his job carried too much responsibility. Financial stresses had recently become acute. He was reassured and seemed to appreciate that his stress could result in persistent sore throat.

However, he continued to do poorly. In November, 1950, seven months later, striking changes had taken place. He had in the previous four months developed typical symptoms of myxedema. He presented, also, typical physical findings of myxedema and his thyroid could not be felt. His BMR was minus 35 per cent. His sore throat persisted, but was over-shadowed by the other symptoms. Within a month he had returned to normal

with thyroid therapy. His sore throat has disappeared.

There seems little doubt that this man had chronic thyroiditis which led to myxedema. We believe that his sore throat was in fact due to thyroiditis rather than psychic tension.

Case 5: A 48 year old woman was first seen in October, 1949, complaining of chest pain, fatigue, and nervousness. At 35 years of age she had one and a half ovaries removed, after which she did not menstruate. In 1943, she was treated at Milledgeville State Hospital for bromide psychosis. In 1946, she was seen by a psychiatrist, who considered her to be paranoid schizophrenic with sex perversion features. Following psychotherapy, she made an excellent adjustment until December, 1948, when she was separated from her husband. During the following months she had lived alone. Fear of another psychic breakdown developed. She became agitated and depressed. In September, 1949, she had an episode of rather severe chest pain. It lasted about one minute and was not typical of anginal pain. Several other milder episodes occurred. They did not follow exertion or over-eating. She believed that emotion did not precipitate them.

Physical examination was essentially negative. Blood pressure was 115/80. Urinalysis and sedimentation rate were normal. An EKG was entirely normal. BMR was minus 9 per cent.

She was told that her pain was the result of anxiety, and was referred back to her psychiatrist. Again she did well until February, 1951, when she had a large coronary occlusion which was fatal. Autopsy revealed a large recent posterior infarction and a small, old, well healed anterior infarct.

We believe this case illustrates an error in judgment. In 1949 negative physical and laboratory findings plus the impressive life history of this woman led us to believe that her pain was not angina. It undoubtedly was.

DISCUSSION

These cases have not been presented as unusual cases. Such experiences are unfortunately too common. The diagnosis of "psychosomatic" disorder should never be made on the basis of negative findings. Furthermore, when positive evidence of psychic disease is present, the physician must be most careful to exclude coexisting organic disease. Even when the latter cannot be demonstrated, the physician must keep an open mind. The difficulty in making a diagnosis often depends on the stage of the

disease. Reexamination and reevaluation at appropriate intervals is preferable to a premature conclusion of psychoneurosis. The error of labeling a condition a neurosis when grave organic disease is present, whether or not it is actually responsible for symptoms, is hard to forgive.

SUMMARY AND CONCLUSION

Five cases have been presented which illustrate erroneous diagnoses of functional disease. Complicated life situations and distorted personalities are common and accurate diagnosis is more difficult when they are encountered.

ABSTRACT OF DISCUSSION

DRS J. A. REDFEARN (Albany) :Dr. Tift and Dr. Hazlehurst have chosen five cases from adults, largely of advanced years. According to Cecil he states that 60 per cent of all illnesses are functional or psychic. Most of it, of course, begins with children; but you see it primarily in young adults when responsibility is heaped upon them. If they are lacking ability to adjust, then they are going to come to you with complaints of a pain here or a pain there, lack of sleep, family difficulties, sex difficulties, and so on.

There is no drug that will dissolve trouble. There is no knife that will cut out this condition. At one time it was said that the repair of lacerations, relieving the rectocele, the cystocele, suspending the uterus, removing the appendix, and puncturing a cystic ovary, would help a patient to get over her "nerves."

The rest in bed, the good nursing, being able to get away from the children, and all those things, did help; but the person got back into the groove, and these symptoms same swarming out of the mind like bees from a hive, and centered around any organ in the body simulating an organic disease.

It is up to you to explain to the patient and help him and show him the way. If the patient is young you can do this easily. It is up to the general practitioners and the internists to do this work, because the psychiatrists we have can't possibly treat more than 10 per cent of such patients.

DISCUSSION OF PAPERS, "DIABETES IN GEORGIA," BY CHRISTOPHER J. McLOUGHLIN, LESTER M. PETRIE AND RICHARD H. FETZ, ATLANTA, AND "THE MEDICAL CARE OF SERVICE CONNECTED DIABETICS IN GEORGIA," BY A. PARK McGINTY, ATLANTA (See Pages 285-289 in *July Journal*).

DR. JAMES E. PAULLIN (Atlanta): For many years I have been greatly interested in the prevalence of diabetes, because it is one disease which, if detected early, will allow a great deal to be accomplished in its treatment. Many of its complications can be stopped and the patient taught to live a pretty normal life.

I am very much surprised about the prevalence of abnormal carbohydrate metabolism in this large group of patients: 3.3 per cent, as given in Dr. McLoughlin's figures.

Of course, not all of those patients have diabetes. They haven't been said to have diabetes. But, on the other hand, it gives us food for thought.

There is one other point which he made, and which I had observed many years before, namely, that colored females run higher blood sugars and usually have more diabetes than the average male. The reason that is that most of them (60-70 per cent) are cooks, they are overweight, and they are constantly being subjected to an increased intake of food.

One of the advantages of such a survey is to call attention to the fact that there does exist preventive measures for treating diabetes. I think the paper by Dr. McGinty is most revealing, and he has clearly demonstrated, even in a short space of time, the fact that a diabetic, well treated, maintains sugar-free urine a greater part of the time and more or less a normal blood sugar, and the complications would be much less frequent than in the uncontrolled diabetic or the diabetic who is allowed to eat anything he wants to, and who is given insulin according to his own judgment.

PROGRAM FOR INTERN TRAINING FOR GENERAL PRACTICE

G. LOMBARD KELLY, M.D., *Augusta*

Within the last decade there has been a soul searching in the medical profession with particular reference to the disproportion between the number of specialists and the number of general practitioners. As the result of the revived interest in general practice a number of recent changes can be cited.

At the end of the active hostilities of World War II recent graduates as well as leaders in medical education became interested in a type of graduate training that would prepare the young physician for general practice and would not lead into specialization in a narrowed field. The two year rotating internship especially designed for training leading to general practice came into being and such internships were offered in hospitals in many sections of the country. There has been of course some disagreement as to just what subjects the two-year rotating internship should cover, but all have tried to stress those subjects which are of greatest importance to physicians engaged in general practice. Further developments may be expected in the development of the syllabus for such a course but the demand for such training apparently has come to stay.

Out of this renaissance of emphasis on general practice, on June 10, 1947, there arose the Academy of General Practice which laid down the regulations by which physicians could qualify for fellowship. One of the principal criteria naturally was a requirement for attending postgraduate courses and attending medical society meetings. The growth and prestige of this organization speak for themselves.

Related to this development, but not definitely a part of it, has been the requirement in some medical schools that medical students spend the summer months between the third and fourth years assisting general practitioners who serve as preceptors for them.

This is a practice that is spreading and it is not unlikely that the majority of the medical schools eventually will either have this requirement, or an alternative such as attending a fourth year curriculum of twelve months with only one month's vacation. In this way the student will not waste a vacation period between his junior and senior years but the majority of them will probably serve preceptorships while others may remain in hospitals or work in Public Health Departments. The feeling is growing that a medical school serves too important a function to be closed approximately twenty-five or thirty per cent of the year. It is not unlikely that a longer curriculum will be developed for all four classes.

Medical literature is now filled with articles and editorials concerning this new trend in medical education. The Journal of the American Medical Association in a recent editorial¹ called attention to some outstanding facts in this regard:

"Last year's Educational Number reported that 42 schools had established programs designed to stimulate the interest of students in careers in general practice. This year there is a further report that 25 medical schools are sponsoring in their affiliated hospitals internships or residencies, or both, that are specifically planned to meet the needs of prospective general practitioners. A number of additional schools report that they have similar programs under consideration."

The editorial also pointed out that an increasing number of schools had included preceptorships with general practitioners as part of the curriculum and that 13 schools were offering preceptorships at that time, nine having established them within the last two years. In this way students in their formative years are placed under the influence of physicians whose careers are dedicated primarily to the general practice of medicine. In the administration of this program it is quite essential to select the best possible pre-

¹Read before the Medical Association of Georgia in annual session, Augusta, April 19, 1951.

ceptors and this can be accomplished through cooperation with the state medical society. It is equally important that students shall not be exposed to preceptors who in any way deviate from the ethical practice of medicine. Therefore, preceptors must be chosen who are of the highest moral character as well as possessing the best qualifications in the art and science of medicine.

Further reference to this editorial shows that polls taken in 19 medical schools in the preceding 12 months reveal that the percentage of students planning to enter general practice has increased from 36 to 47 in the last three years. The percentage planning to specialize decreased from 36 to 31. Some of the students polled had not made a final decision. It was also pointed out that many forces influence medical students in the choice of a career and it may be that the public will finally decide how many specialists there should be by relying on the general practitioners to a larger degree, rather than by making their own diagnosis and going direct to specialists as some individuals are inclined to do.

Dr. Wingate M. Johnson, in an article entitled "Preparing the Medical Student for Family Practice",² called attention to some of the factors influencing this trend toward greater emphasis on general practice. He refers to the alarming trend toward specialization in the last few years and attributes some of it to the premium placed on specialists in the late war. The development of specialty boards with their very high requirements for certification in the different fields of medicine and the tendency of many hospitals to close their doors to noncertified men has played a large part in the overemphasis that medical students and recent graduates have placed on the need for specialization. Added to those influences has been the pseudoprosperity existing during and since the war, the increasing popularity of group practice and also some current trends in modern medical education. Dr. Johnson concludes that no more than 18 per cent of physicians need to be specialists and he claims that at least two thirds of graduates should plan for a general practice. He re-

ported, however, in one school 96 per cent of a recent graduating class plans to specialize. He considered that this trend seriously threatens the future of the medical welfare of this country and points to certain conditions in metropolitan areas in the worst part of the depression between 1930 and 1935.

"It must be remembered that during the last depression many physicians were operating taxicabs and elevators. None of these were family physicians. Patients are now complaining that they cannot find doctors who will come to their homes when necessary. Unless public demand is met, politicians who promise free medical care for all will find ready followers and physicians will find themselves ordered to practice when, where and how the government directs."

It is stated that of certain factors which have helped attract students to family practice, the most important is the actual teaching program in which emphasis is placed on consideration of the whole patient. In this method the student is given early responsibility for the care of patients, although under supervision. In most schools the fourth year class is divided into three sections: medicine, surgery, and specialties. In the Medical College of Georgia since 1925 the class has been divided into medicine, surgery, and domiciliary medicine. At least one other school has followed this lead. In domiciliary medicine, medical students have considerable responsibility in the care of patients but in addition they see patients who are not ill enough to be hospitalized but are too ill to go to the out-patient department. This is the type of patient which the general practitioner sees in the home, but few medical students ever see this type of patient before they enter practice, with the exception of those seen on the outside obstetrical service. In some schools the environment of a patient has been stressed and some students accompany social service workers and nurses who attend patients in the home. This is quite different, however, from having the student take the history and do the physical on each patient and attempt to arrive at the diagnosis. In all our domiciliary care by medical

students, a chart is kept on each patient and weekly history meetings are held by the supervisor of the course.

Dr. Johnson elaborates on a special course in family practice which is given one hour a week and attended by both the junior and senior students:

"This class combines the old didactic lecture and the modern bedside clinic. This course is made as informal as possible. Students are encouraged to interrupt with questions at any time and to challenge statement or diagnosis; no infallibility is thrown about the teacher nor effort made to bluff the student. Cases selected for presentation are typical of those seen in general practice. Some cases are purely functional, some organic, some mixed, and the student handling the cases is made to dig in the history of the patient until the mental focus in cases of psychoneurosis is found by tactful questioning. Occasionally, for the good of his soul and the benefit of the student, the teacher presents one of his own mistakes in diagnosis or therapy. All through the course an effort is made to emphasize the importance of the history and the physical examination. A preceptorship system has been inaugurated wherein, due to the fact that classes are graduated in December while most hospital appointments begin in July, a large number of graduates accept a preceptorship under a family physician. Since they have the rights and privileges that go with licensure, they become real assets to the preceptors. This practice encourages young men to become family physicians themselves."

In a paper entitled "Preparing the Intern for General Practice,"²³ Dr. Myron McDonald Weaver makes several pertinent recommendations. He states that the majority of recent medical graduates hesitate to enter practice without special training because they do not feel they are qualified to do so after a one-year internship. He considers their feeling of inadequacy arises from the impossibility of mastering the required medical knowledge in five years. He cites the suggestions made two years ago by Dr. William A. O'Brien as follows:

"There should be a redistribution of emphasis in the curriculum of the four year medical course, with relatively more attention to internal medicine, medical specialties, obstetrics and pediatrics, due regard for medical aspects of surgical specialties, and that technical aspects of surgery be left for the graduate years. Recent medical graduates should be able to avail themselves of an internship that offers special training for general practice beginning with a full year in medicine and the medical specialties followed by a second year in obstetrics, pediatrics and some aspects of surgery."

Dr. Weaver cites the following advantages of training for general practice:³

"Two full years of good hospital experience; responsibilities which are seldom accorded rotating interns; experience with types of patients and stages of disease which are encountered in both public and private hospitals; valuable types of experience with hospital administration, and opportunity to return to the medical school for regular medical-surgical-pathologic conferences and other exercises."

In a discussion of the papers by Drs. Johnson and Weaver, Dr. Ward Darley cites some important facts.^{2 3} Specialization has been a necessary and beneficial development in medical practice and is here to stay, but it is essential that someone in the medical family be prepared to fill the gap between the patient as a person and his occasional needs for a specialist. In this discussion emphasis was laid on the concept of Dr. Lester Evans that physician training should be as follows:

"The training and educational experience of every physician should emphasize the concept of continued medical care of the individual, and this means that the physician's primary interest should center around the care of the ambulant patient. The physician should get away from the idea that the hospital is the center of medical practice. He should believe that the care of the ambulant patient is the important aspect and that hospitalization is something incidental to this care."

There is no doubt that approved residencies for general practice would find an ample list of applicants. One reason that many students begin specialization early after graduation is because the type of training they can obtain in specialty training is superior to that which in the past has been available for general practice training. If the quality of general practice training is placed on the same level as the quality of specialty training there will be a good supply of takers of such residencies for general practice.

It is encouraging to note that in December, 1948, the Council on Medical Education and Hospitals adopted standards for approval of residencies in general practice and the hospitals which were approved under the residency classification were informed that they would be expected to organize their training program in accordance with the new requirements if they wished to retain their approved status.⁴ The present writer feels that greater emphasis should be laid on training in general surgery in such residencies since the majority of general practitioners will desire to do certain of the less difficult operations in major surgery although they would not attempt to do operations of the more difficult type. Recent graduates are inquiring more and more about the two-year rotating internship or the general practice residency, and if such training of high quality is provided it will be eagerly sought after by the recent graduate and it will also bring about a marked improvement in the quality of general medical care.

The present writer agrees with Dr. Roy C. Crosby who drew the following conclusions in a recent report:⁵

"The provision of optimum training for medical graduates intending to go into general practice is one of the more difficult problems with which those interested in graduate medical education must contend. Ideally, since a large part of the general practitioner's work will be in the field of general medicine, a prolonged period of medical training is advisable. Since he will be called upon to perform major surgical procedures, at least those of emergency nature, he should be well trained in basic surgical principles and particularly trained to

perform those surgical procedures which he may be called upon to perform. Fracture work will often fall to his lot if it is to be promptly and competently handled as it must be for good end results. The American Academy of Pediatrics has found that 75 per cent of the medical care of children in this country is provided by general practitioners. The necessity for pediatric training is obvious. Similarly, the practice of better obstetrics necessitates the better training of general practitioners. The necessity for pediatric training is obvious. Similarly, the practice of better obstetrics necessitates the better training of general practitioners in this field since they provide the major part of obstetric care in this country. It therefore becomes obvious that ideally the general practitioner should have sufficient periods of time in his graduate training to acquire some skill at diagnostic and therapeutic medicine, surgery, orthopedics, obstetrics, and pediatrics, which would obviously involve several years of training after medical school . . ."

Reference is here made to the report of the Committee on General Practice appointed in June, 1949, by the Board of Trustees of the American Medical Association on instruction of the House of Delegates. This report appeared in the *Journal of the American Medical Association*.⁶ It is too long to be considered here in detail, but the writer is in agreement with the general conclusions. The committee noted that a higher quality of specialists would be obtained if the candidate for any field of specialization were taken from the ranks of the general practitioner with several years experience in practice. This has been the conclusion reached by physicians in general over a long period of years.

It is felt wise to make reference here also to the Manual on the Establishment and Operation of a Department of General Practice in Hospitals prepared by the Committee on Hospitals of the American Academy of General Practice.⁷

The faculty of the Medical College of Georgia has considered the adoption of methods of training comparable to the foregoing. It is not unlikely that preceptorships

for students between the junior and senior years will be begun in the near future and it is hoped that in the very near future approved residencies for general practice will be made available in the affiliated teaching hospitals, particularly in the proposed State general hospital, construction of which may be started in January, 1952.

The State general hospital can serve as a keystone in the arch between medical education and medical care, and it will be possible to rotate interns, assistant residents and residents between the State hospital on the campus of the school of medicine and the various State hospitals and possibly also some of the newer hospitals constructed with the aid of Hill-Burton funds. It is likely also that some faculty members may be rotated in order to provide approved resident training in the State hospitals for the rotating resident staff members. It is expected also that the large general State hospital will be able to train more nurses and technicians which will also help to supply personnel which is badly needed in the State hospitals and in the smaller hospitals.

A completely satisfactory functioning of this plan of integration will have a threefold effect upon medical education and medical care in our commonwealth: (1) It will increase the number of approved internships and residencies in the State and make it possible to keep more of the graduates of medical schools in Georgia within the State for their postgraduate training. This will mean that fewer of them will locate elsewhere,

which is often the case when they serve internships and residencies outside the state. (2) It will provide a higher type of medical care for the inmates of State institutions where the hospitals will be placed in part on a teaching basis and in part on a semi-teaching basis. (3) It will provide a type of medical training that will in the long run provide more and better doctors for the State as a whole.

It is apparent to any careful observer in the realm of medical education that this field of training is in a state of flux. Medical educators everywhere are seeking better methods, better curricula and greater emphasis on the most important phases of medical care. It is not unlikely that improvements in audio-visual education will provide time-saving methods in all four years of the medical curriculum and that a common-sense approach to methods of training medical students in the art and science of medicine will be developed rapidly as time goes on.

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LAST-MINUTE MEDICAL NEWS

THE NATIONAL GASTROENTEROLOGICAL ASSOCIATION will hold its Annual Session at The Drake in Chicago on September 17, 18 and 19. Immediately following the convention, on September 20, 21 and 22, the Association will conduct a postgraduate course in gastroenterology at The Drake, under the direction of Drs. O. H. Wangenstein, Minneapolis, and I. Snapper, New York City.

SENATE BILL 349, HOSPITAL AID LEGISLATION, has moved closer toward enactment. Presented as the Administration's defense housing and community facilities bill, it has been favorably reported to the House floor by the Banking and Currency Committee and has been amended to place the Surgeon General of the U. S. Public Health Service in charge of all hospital, public

health and sanitation phases of the program. It authorizes \$100 million in Federal funds for loans and grants to promote construction of community facilities (including hospitals). Senate concurrence would mean that hospital aid would be handled by the same branch of the U. S. Public Health Service that administers the Hill-Burton program, thus minimizing chances of conflict and duplication in Federally-assisted hospital expansion.

HILL-BURTON PROGRAM ALLOCATION for Georgia in 1952 has been announced to be \$3,068,889. The allocation was arrived at from a statutory formula, the principal factors of which were population and per capita income.

MEDICAL CONFERENCE AT EMORY UNIVERSITY HOSPITAL

PROTEIN BOUND IODINE

Speaker: BERNARD L. HALLMAN, M.D., *Atlanta*

Long suspected as a good test for thyroid function, many investigators have attempted to find some way to measure blood iodine and to correlate the test with thyroid function. Some of the earlier attempts were very crude, for instance, one of the first devised by Bourcet and Gley¹ in 1899 required a whole liter of dog's blood in order to do one determination.

The first fairly successful tests were set up to do total blood iodine, instead of the protein bound iodine. Of course, these normals ranged much higher than the protein bound iodine and were subject to wide variations. A large amount of literature appeared trying to correlate total blood iodines with thyroid disease and with many other diseases. All of this work was very rapidly proved to be incorrect, however, and the investigation turned toward the protein bound iodine.

For many years it has been known that the largest fraction of the total blood iodine was non-diffusible. It was suspected that this fraction was bound to a protein molecule. For about 51 years now the work on protein bound iodines has followed three separate routes: (1) Attempts to precipitate this protein fraction. (2) Devise a chemical method accurate enough to measure these very small amounts of iodine in samples of serum or plasma. (3) Discover just what the PBI means and how it is related to thyroid function. Today it is generally accepted that the PBI is a measure of the actual blood circulating thyroid hormone, and that its fluctuations reflect increases and decreases in thyroid function. Up until recently all of the laboratory procedures for determining the PBI had many disadvantages. They were very difficult to run; required special labs, expensive equipment and specially trained

personnel. For these reasons the tests were limited to research purposes only.

The method we are using is the method of Barker and Humphrey,² which is a fairly complicated test but simple enough for routine use in a general hospital. In general, the steps for running the PBI are as follows:

1. Precipitate and washing serum protein—precipitate with ten percent zinc sulfate and five normal sodium hydroxide solution, centrifuge and wash with distilled water three times.
2. Drying and incineration—resuspend in four normal sodium carbonate solution and dry in an oven between 85-95°C. (requires 12-18 hours). Then place tube in a muffle furnace and heat to 600° ($\pm 25^\circ$) for 2½ hours.
3. Dissolving iodine from the ash—2 cc. of two normal hydrochloric acid solution added plus 2 cc. of seven normal sulfuric acid and 3 cc. of distilled water. Centrifuge.
4. Determination of iodide—accomplished by measuring iodide catalysis of the rate of decolorization of yellow ceric ammonium sulfate by arsenious acid. Colorimetric readings made at 6 and 12 minutes establishes the rate at which the solution is decolorized. This rate is in proportion to the amount of iodide present and acting as the catalyst.

During the past year we ran over 3,000 determinations of the PBI in our lab at Grady Hospital. These were run on over 1,600 patients. The mean normal value based on 37 normal subjects was found to be 5.4 mcgm. per 100 ml. with a normal distribution. The standard deviation was 1.08 mcgm. per 100 ml., indicating that 95 per cent of the normals will fall between 3.2 and 7.6 mcgm. per 100 ml. (Fig. 1). In practice, we have considered the limits of normal to be 3.2-8.0 mcgm. per 100 ml. The accuracy of the method was tested by performing 10 determinations on aliquots of

Weekly Medical Conference, given on July 23, 1951, at the Emory University Hospital.

NOTE: Much of this material was recently presented in a paper entitled, "Determination of the Serum Protein Bound Iodine as a Routine Clinical Procedure," Hallman, B. L.; Bondy, P. K., and Hagewood, M. A. *Archives of Int. Medicine* 87: 817, 1951.

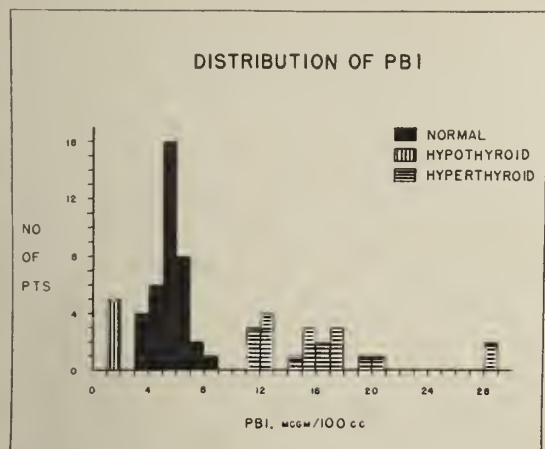


Fig. 1. Distribution of PBI in normal subjects and in patients whose thyroid disease was confirmed by a satisfactory response to appropriate treatment. (Reprinted, Courtesy *Archives of Internal Medicine*.)

a single sample. This showed the standard deviation of the method to be 0.24 mcgm. per 100 ml. at a level of 6.0 mcgm. per 100 ml., indicating that differences of 1.0 mcgm. per 100 ml. can be detected in duplicate samples with a probability of 95 per cent. In hyperthyroid patients, the PBI was higher, and in hypothyroid patients, it was lower than the normal range (Fig. 1).

Pregnant women have an elevated PBI. In a series of 14 normal women in the fifth to eighth month of gestation, the mean PBI was 10.2 mcgm. per 100 ml. Ninety-five per cent of such patients can be expected to fall within the range of 6.8 to 13.6 mcgm. per 100 ml. The cause of this increase is not known. It may be due to some slight hypertrophy of the mother's thyroid during pregnancy. It probably is not due to any influence from the gland of the fetus as the increase is noted earlier than the time when the fetal thyroid becomes functional.

Dr. Harvey Hamff: Does the PBI fluctuate during the course of pregnancy, i.e., is the PBI higher the eighth than third month?

Dr. Hallman: No sir, usually it remains in approximately the same range throughout pregnancy.

Dr. David James: Another kind of thyroid enlargement which has always been said to be similar to the thyroid enlargement which occurs during pregnancy, is that which occurs at puberty. Are there any data to indicate that the PBI goes up during the pubes-

cent period when frequently you see enlargement of the thyroid?

Dr. Hallman: No sir, in a review of the literature by Rapport and Curtis,¹ no fluctuations in the PBI's were found in any age groups.

In an attempt to decide if our PBI's were running with any degree of accuracy with the BMR's, we checked 30 patients who had both PBI's and BMR's. It shows a very good correlation between the PBI's and the BMR's in this particular group (Fig. 2).

There are several obvious sources of error in running the test itself. The presence of iodine vapors in the laboratory will cause an increase in the tests being run. If the samples sit around too long, the readings will go up. Safely, a sample can be run if it is not over a week old. After a week it will read about 1 to 2 micrograms/100 ml. higher. Of course, the most common error at first was the practice of using tincture of iodine to swab off the patient's skin when drawing blood.

There are certain advantages of the PBI test for thyroid function and probably the most obvious one is that blood can be drawn at any time. Whenever this diagnostic possibility arises, 10 cc. of blood may be drawn in a dry test tube and sent to the nearest laboratory for analysis. This may be at any time of the day, before or after meals, and without regard to the patient's general physical condition. The fact that the patient is not in a basal state, is nervous, or has fever, does not interfere with the test. This test is readily available to practitioners in isolated rural areas, since serum specimens can be mailed to a central laboratory without any loss in accuracy.

In cases where the clinical picture of thyrotoxicosis or myxedema is clear-cut, the PBI, like the BMR, is merely a confirmatory tool. In our cases we ran both BMR's and PBI's on each patient. In cases where a good BMR tracing was obtained there was a definite relationship between the height of the PBI and the BMR (Fig. 2).

In certain cases where it was impossible to obtain an accurate BMR, the PBI was solely responsible for making the diagnosis. This has been especially true in patients with

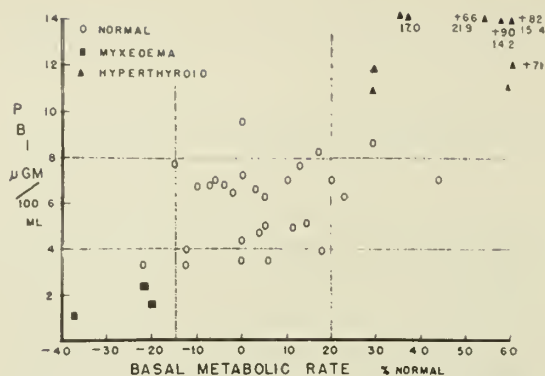


Fig. 2. Relationship between PBI and BMR. (Reprinted, Courtesy *Archives of Internal Medicine*.)

congestive heart failure complicated by hyperthyroidism or myxedema.

Congestive Heart Failure

The following two cases illustrate the advantages of the PBI in making a diagnosis of thyrotoxicosis or myxedema in the presence of congestive failure.

Case 1. A 57 year old white male complained of shortness of breath and swelling of his feet and legs. For about five years he had noted weakness, nervousness and weight loss, and during the past six months his heart had seemed to "jump around" and "skip beats." His legs had swollen rapidly during the two weeks before admission. His appetite had remained good throughout his illness and he had noticed increasing intolerance to hot weather. The patient was admitted in acute pulmonary edema. He was thin, nervous, very excitable and appeared acutely ill. His blood pressure was 130/70. His pulse was grossly irregular, the rate being 130 to 140 per minute. He had a moderately large, smooth goiter. The heart was moderately enlarged. The liver was slightly enlarged and tender. There was severe pitting edema of the legs and ankles. Electrocardiogram revealed auricular fibrillation. Thyrotoxic heart disease with congestive failure was suspected. Determination of the BMR was obviously not possible; however, the PBI was found to be 11.4 mcgm. per 100 ml. He was treated with the usual cardiac medications and methyl-mercaptoimidazole ("Tapazol," Lilly*), 20 mg. per day, and gradually improved. When he was considered euthyroid he was treated with I-131 and made an excellent recovery.

Case 2. A 40 year old colored male was admitted because of massive edema. He had been ill for six years with dyspnea on exertion, ankle edema and progressive weakness. He had been told that he had "kidney trouble" and high blood pressure. His edema had gradually become worse

and his sensorium had become more and more clouded until he was so somnolent that he could only be aroused with difficulty. On the basis of his preliminary clinical studies he was believed to be in the nephrotic phase of chronic glomerulonephritis. The admission physical examination showed generalized edema, including the eyelids, right pleural effusion, massive ascites and pitting edema of both legs and feet. The skin was thick and dry. The heart was greatly enlarged. The blood pressure was 140/110. He had a moderate anemia, a positive Kahn (32 Kahn units), and normal NPN. The cholesterol was 355 mg. per 100 ml. and the plasma protein 6.8 Gm. per 100 ml. The urine was normal except for a few WBC and RBC and occasional hyalin cast. The nephrotic syndrome appeared to be an unlikely diagnosis because of the absence of albuminuria and the normal plasma proteins, and the possibility of myxedema heart disease with congestive failure was considered. The patient was too sick to cooperate in determining his BMR. The protein bound iodine was 1.2 mcgm. per 100 ml. A diagnosis of myxedema was made and treatment with thyroid extract was begun. He gradually improved and was discharged after 42 days in the hospital. He is now clinically completely well on 120 mg. per day of thyroid extract.

In the first case the diagnosis of thyrotoxicosis was suspected clinically and was merely confirmed by the elevated PBI. In the second case the patient was admitted as a case of the nephrotic syndrome and was thought to be moribund. The true diagnosis was obvious as soon as the extremely low PBI was obtained.

Mentally disturbed patients: In psychotic or disturbed patients it is often difficult to determine whether abnormalities of thyroid function are playing a part in the development of the mental disorder. Moreover, if patients who are already psychotic develop thyroid disease, the diagnosis may be impossible to establish by ordinary means. This situation is illustrated in the following case:

Case 3. A 44 year old white female was admitted for study, with a chief complaint of tarry stools occurring at intervals for the past 10 years. Almost immediately it was apparent that the patient was psychotic and the history was entirely unreliable. Her complaints covered the full range and changed from hour to hour. Physically, the patient was a small, thin, active woman. She weighed 115 lbs. The blood pressure was 115/70; pulse rate and temperature were normal. The findings on physical examination were not remarkable. The laboratory work was normal except for a moderate hypochromic microcytic anemia which was thought to be on the basis of poor nutrition. A psychiatrist saw the patient and thought she was severely psychotic and possibly suicidal, but the type of psychosis was not clear. One observer thought her hair and skin felt dry and coarse and suggested the possibility of myxe-

*Kindly supplied by Dr. D. C. Hines, Eli Lilly Co., Indianapolis, Ind.

dema. Subsequent laboratory studies revealed the serum cholesterol to be 310 mg. per 100 ml. and the protein bound iodine 1.2 mcgm. per 100 ml. A BMR was impossible because she could not cooperate. A diagnosis of myxedema was made and the patient was started on thyroid extract. The PBI rose gradually to a normal value, the serum cholesterol fell to 200 mg. per 100 ml. and the signs of myxedema disappeared. After three months of therapy her mental state returned to normal.

Pediatric patients: Although thyrotoxicosis is uncommon in pediatric practice, it is occasionally seen. The diagnosis is difficult because the hyperthyroid child is often no more active than a normal child of the same age. Furthermore, it may be difficult to obtain a BMR because of lack of cooperation. In this type of patient, the PBI may clinch the diagnosis without difficulty. This problem arose in the following cases:

Case 4. A 3 year old colored child was brought to the clinic because of a "swelling in his neck." His parents had noticed no other peculiar behavior or symptoms; however, on questioning they stated that he was very active and had good appetite. Physically, he appeared to be a normal child, possibly a little brighter and more active than usual for his age. There was a small, smooth, palpable goiter without bruit. The heart rate was about 140; the blood pressure was normal. The laboratory work was normal except for the PBI which was 20.1 mcgm. per 100 ml. A BMR was attempted every morning for a week before an acceptable tracing was obtained, which showed the rate to be plus 54 per cent. The patient is now being treated with antithyroid drugs and his course is being followed by weekly determinations of the PBI.

Case 5. No abnormalities had occurred in this patient's development until the age of three years, when the child's mother noticed a gradual increase in the size of the right side of the neck. There were no symptoms, and development was normal until, at the age of five, the enlargement of the neck was called to the attention of a pediatrician. He heard a bruit over the area and advised admission for study of thyroid function. Physical examination showed a fretful, uncooperative, nervous child. The pulse rate was rapid and the cardiac impulse forceful. There was a diffuse enlargement of the right supraclavicular area, and a loud bruit with systolic accentuation was heard. A thrill could also be palpated in this region. The diagnosis of hyperthyroidism was considered, but it was found impossible to determine the basal metabolic rate. The PBI was normal on two occasions, and a diagnosis of arteriovenous fistula was thought to be the cause of the bruit. Since arteriography of vessels in the base of the neck is a major surgical procedure and the child was not inconvenienced by her disease, further studies were postponed.

In these cases, the PBI gave valuable aid in reaching the diagnosis. In the second case, particularly, the hyperactive circulation caused by the fistula mimicked the signs of thyrotoxicosis and made diagnosis difficult.

Use of the PBI in following the course of antithyroid therapy. In many patients such as those discussed, it is impossible to follow the course of the patient under antithyroid medication by the BMR. In such patients, the PBI offers a method for determining whether the patient is being brought under control. Even in patients in whom the BMR is adequate, the PBI supplies additional information. We have observed that the PBI usually falls to normal within a week or 10 days after the institution of adequate therapy with one of the thiouracil drugs, regardless of the original level of the PBI. This effect may precede the improvement in the clinical signs and the BMR by several weeks. The PBI, therefore, may serve as an early index of the effectiveness of antithyroid medication.

The PBI determination suffers from a serious defect in being unable to distinguish between the iodine of thyroid hormone and the iodine of radiopaque dyes circulating in the blood. However, the administration of inorganic iodides, in the form of potassium iodide or Lugol's solution, may also cause significant alterations of the PBI concentration. For accurate results, therefore, the PBI should not be determined in patients who have recently been receiving therapeutic doses of iodides, or who have had x-ray studies with radiopaque dyes.

How long must one wait after the administration of iodine-containing dyes before the PBI returns to normal? No absolute answer can be given. After the injection of this type of material into the subarachnoid space, it is probable that the PBI will always remain elevated. Gallbladder dyes may cause abnormally high values for as long as six months. The excretion of these substances is slow because they are continually reabsorbed from the intestines and reexcreted into the bile. The renal excretory dyes, such as those used for excretory urograms or angiocardigrams, are eliminated relatively rapidly, so that their effects have often dis-

appeared within three to four weeks. Bronchograms and retrograde pyelograms appear to have little effect on the PBI, and their effect is short lived, usually disappearing in less than a week.

Dr. Gratton Woodson: Dr. Hallman, how about the bronchograms where you can actually see the dye in x-rays after a couple of weeks?

Dr. Hallman: For some reason it doesn't seem to be absorbed very well. We can see large amounts of it and still be within a normal range. Of course, if the patient's normal value happened to be borderline, then any elevation would be confusing.

After the administration of inorganic iodides in small doses (e.g., Sat. Sol. KI, 0.5 to 1.0 cc. daily for several weeks), the PBI may remain elevated for as long as 30 days³. Massive doses of iodides, such as might be used in the treatment of fungus infections, may continue to exert their effects for as long as one to four months.⁴ Although small doses of inorganic iodides do cause some increase in the PBI concentration, the effect is small (usually less than 3 mcgm. per 100 ml.), and, therefore, is not a source of error except in evaluating patients with borderline hyperthyroidism.

Since the colorimetric method used for the estimation of the PBI is influenced by small amounts of mercury, the influence of mercurial diuretics on the PBI was investigated. No alteration in the PBI occurred after the intramuscular injection of 2.0 ml. of mercurhydrin.

The influence of other halogens must also be considered. Chloride and fluoride are without effect. Large amounts of bromine appear to have a minimal influence on the iodine method. A plasma concentration of 100 mg. per 100 ml. of bromide would produce an increase of the PBI of about 0.5 mcgm. per 100 ml., if the bromide remained entirely in the analyzed sample. The protein precipitate is washed three times, however, and only very small traces of inorganic halogens remain behind after this washing. The influence of bromide ion is, therefore, inconsequential and can be ignored.

We feel that we should mention the I-131 uptake test. In comparison with the PBI,

we find that this test for thyroid function has all the disadvantages that the PBI has. First, of course, it is disturbed by previous iodine medications. Second, (this would not apply to the PBI) it cannot be repeated frequently. Third, it is very expensive and requires specially trained personnel and expensive equipment. It also requires the presence of the patient. It is impossible to mail in blood samples and ask for an I-131 test.⁵

We feel that there are definite indications for ordering the PBI test: (1) When the BMR is impossible as in heart failure, (2) to follow the early course of therapy, (3) to confirm the BMR findings when they seem incongruous to the clinical picture in the patient. The test is somewhat expensive and should not be used as a screening test for thyroid diseases. It certainly cannot substitute for a good history and physical examination.

In conclusion, we have found that the PBI is a very helpful test only as an additional lab test, or as additional data in evaluating myxedema and hyperthyroidism. We do not think it will replace any of the other tests. It will not replace the iodine uptake, as we have seen one or two cases diagnosed by the I-131 uptake, that had normal PBI's. The BMR should not be replaced because it comes closer to measuring what we really want to know about thyroid patients than anything else. The BMR measures the actual rate of metabolism. Of course, it has its limitations as everyone is well aware. We feel that no test should replace a good clinical evaluation of the patient, as this is still the best means of diagnosing all forms of thyroid disease.

Discussion Period

Dr. James: Will anxiety give you a false test?

Dr. Hallman: No, it will not. We have not found this to be so in our series or in our survey of the literature. We are still working on this and may alter this opinion later, but we don't think so right now.

Dr. Willis Hurst: The PBI reports that disturb me are those around 8 or 9 or so. I frequently have to go entirely on my clinical judgment when they are in that range. I

have treated patients who seemed toxic clinically but who had PBI's in this range.

Dr. Hallman: I think you were perfectly right. Nine micrograms usually is considered a positive test. Of course, a report in this range should be repeated to rule out possible lab errors. If the patient isn't in too much trouble it might be better to wait a month or two and then repeat the test. By then it may have risen to a level that would make the answer certain.

Dr. Hurst: Dr. Bondy mentioned the other day, I think, that the statistical chances were about 1 in 200 that the patient doesn't have hyperthyroidism if the PBI is 9 mcgms/100 ml. and has been found to be that on at least two occasions.

Dr. Hallman: It's even better than that in myxedema. We get normals down to about 3 or 3.5, but usually if a patient really has myxedema, the PBI will be definitely low. There seems to be no confusing borderline between myxedema and normal.

Dr. Hurst: There's a patient at Grady right this minute with congestive heart failure and auricular fibrillation, due to rheumatic heart disease. The clinical picture of this patient is that of thyrotoxicosis but his PBI is normal. This is the sort of patient that I would treat anyway.

Dr. Hallman: This is the sort of patient I would order a I-131 uptake test for additional information before I started his antithyroid therapy.

Dr. James: I've ordered a lot of PBI's on patients whom I've seen in the last year, and somehow or other I have the impression (I'll readily admit that it's vague), that there are more false positives and more false negatives than you've discovered. I intend to keep a little file of my own PBI results, because I don't believe the test is entirely accurate. I'm sure it's hard to suggest this when I have no data to support the opinion.

Dr. Hallman: Are you comparing it with your clinical judgment only?

Dr. James: Yes sir.

Dr. Hallman: Any other laboratory tests, BMR, I-131 test, etc.?

Dr. James: Oh no, just my judgment as to whether or not the patient has thyrotoxicosis.

That's what one has to do because that's how you got your normals. It necessarily comes back to that. The thought came to me when Dr. Hallman was telling about the patients that did so well on antithyroid drugs and I-131. That doesn't necessarily mean that they have thyrotoxic heart disease. As we well know they got a great deal of other treatment during this period, despite the fact that they'd been resistant before. Also, I would like to point out that most all patients with chronic congestive heart failure and angina pectoris seem to improve with antithyroid therapy if pushed to the myxedema level. Of course, there have been some disadvantages to this treatment as a routine procedure.

Dr. Hurst: What Dr. James says is right. Many forms of heart failure will get better.

Dr. Hallman: Do you have to get them down to normal (low) range or to a myxedema range to get better?

Dr. Hurst: Almost to myxedema in my experience.

Dr. Hallman: These patients who we included in the series did not go to myxedema level.

Dr. James: Are there any other comments or questions?

Dr. Elizabeth Adams: Do patients with carcinoma of the thyroid show any change in the PBI?

Dr. Hallman: The PBI is usually normal in cancer of the thyroid.

Dr. Adams: How about simple, nonfunctioning nodules?

Dr. Hallman: The PBI wouldn't help in that case. It's no help at all in carcinoma or thyroiditis.

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THE JOURNAL

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AUGUST, 1951

As this issue of *The Journal* goes to press, we announce with sadness the passing of Doctor James Edgar Paulin, who was President of the Medical Association of Georgia in 1935-36.

WHO SHALL PRACTICE MEDICINE IN GEORGIA

Each week reports come into the offices of the Medical Association of Georgia concerning the professional activities of various cults in localities throughout the State. Apparently, in numerous instances, they are actually practicing medicine, assuming all the prerogatives and carrying out the various procedures reserved for trained and experienced doctors of medicine.

Unfortunately, they have had, on occasion, the indirect support of some of the pharmaceutical profession who fill their prescriptions for antibiotics, opiates, and other dangerous drugs. Only by openly calling to the attention of these druggists their errors, has some degree of cooperation been obtained.

The actual performance of surgical operations behind the closed doors of cultists' offices and without any checks or supervision has been reported. Naturally, to attempt the performance of illegal operations becomes a temptation too great to resist, and the legitimate doctors have then to deal with these unfortunate individuals when complications arise. Occasional deaths have been reported as a result of such operations.

One would suppose that the presumed shortage of doctors in some of the rural areas would be considered a causative factor in the breeding of such practices, but the reports come from areas that are abundantly supplied with well-trained medical representatives. Cultists are said to be practicing

medicine in all areas, including our larger cities, without interference from the police or prosecuting authorities.

A study of our present laws reveals the astounding fact that our medical practice act contains practically "no teeth" to curb illegal medical practice by cultists, or even licensed, but unscrupulous, physicians, to any extent. The control of medical practice is under the State Board of Medical Examiners, but the Board has neither means to carry out investigations nor authority to prosecute, unless local authorities originate criminal action. Usually this is extremely difficult to originate because of the influence that the criminals are able to exert locally, plus the fact that physicians are loath to start legal action that rightfully belongs to the prosecuting attorney. That has the additional disadvantage of putting the physician in a bad light of not wanting competition, and paradoxically places the illegal practitioners in the role of hero.

Other states have recognized the weakness of their laws and have plugged the gaps through which these activities escape proper legal action. Our neighboring state of Tennessee has a new law that has become a model for other states to follow. At the present time, our Committee on Legislation has this law under study, with the thought of making recommendations to the people in the counties as to methods of improving their protection. Certainly it is time for such action and members of the medical profession are again demonstrating their responsibility as citizens in the community, as well as doctors.

"HATS OFF" DUE COMMISSION ON ALCOHOLISM

The Georgia Commission on Alcoholism is to be commended.

It has recognized from the start that both proper treatment and rehabilitation of the alcoholic largely will fall to the responsibility of the family physician when the public is made aware that alcoholism is a physical symptom of mental and emotional disorder and not merely a lack of moral stability.

Such a program of education is exactly what the Commission intends to undertake

initially in the months to come, crystallizing its findings into a positive program of objectives for presentation to the Georgia Legislature next January.

These points were carefully outlined to representatives from cooperating state agencies, including the Medical Association of Georgia, at a special meeting of the Commission in Atlanta on July 20.

Major participants at the round-table conference included Dr. Paul H. Stevenson of Washington, D. C., Chief of State Surveys on Alcoholism for the United States Public Health Service; Dr. William G. Hollister of Atlanta, USPHS Regional Consultant in Mental Health; Dr. R. Hugh Wood, Dean, Emory University School of Medicine; Dr. Carl Whitaker, Psychiatry Department, Emory University School of Medicine; Dr. T. F. Sellers of Atlanta, Director, Georgia Department of Public Health, and Senator G. Elliott Hagen of Sylvania, original sponsor of the bill creating the Commission at the last State Legislature.

In the discussion, the fact was emphasized that the Commission will not concern itself either with the so-called occasional drinker or the psychotic drinker. Its objective, to the contrary, will be to reach those on the brink of excessive alcoholism who are aware of their plight and honestly desire to do something about it.

As a major part of its education campaign, the Commission, aware that many older physicians may desire short clinical courses on treatment of alcoholism, proposes the holding of such courses throughout the state later in the year, under the direction of qualified specialists. Through cooperation of the Medical Association of Georgia, the Commission will furnish physicians with necessary details in advance of the programs in order that their attendance will be facilitated.

The Georgia Commission on Alcoholism is composed of the following members: Charlie Collins, Atlanta, Chairman; Harold W. McRae, Mt. Vernon, Secretary; Paul H. Fraser, Atlanta, Acting Executive Director; Mrs. Callye H. Neese, Atlanta, Executive Secretary, and Dr. T. F. Sellers and Charles B. Methvin, both of Atlanta; Judge J. Henry

Howard, Sylvania; Rev. Charles C. Duncan, Camilla, and Mrs. Myra Bonner, Milledgeville.

The forty-first State to create a Commission on Alcoholism, Georgia may profitably make use of the suggestions and recommendations to be offered by other states, particularly with reference to the establishment of a close working relationship between the Commission and the medical profession.

THE PROGRAM FOR THE 1952 SESSION

The Scientific programs presented at the Annual Sessions in the past have been a matter of considerable discussion by many members, but up to now no significant changes have ever been made. In the meantime, our neighboring states have quietly gone to work and carried out certain changes that have brought their attendance to the four-figure mark as one example of increased interest.

The committee in charge of the program for our Association met in Macon recently and studied at great length the problems involved. Reports were made by members who have attended and taken part in the sessions of the North Carolina and Florida Medical Associations, which have had the greatest success in improving their meetings. Consideration was also given to the many complaints that have come in following our most recent session in Augusta, including such details as the failure of essayists to supply discussers with copies of their papers, the short time allotted for each paper, and the lack of general interest which caused even high officials of the Association to take to the golf course rather than attend the general sessions.

Finally, revolutionary changes in the style and manner of arranging the program for the 1952 session in Atlanta were made and they deserve your serious consideration. In another portion of *The Journal* a complete report of the Committee's actions will be found, and the first change that you will note moves the meeting days to the beginning of the week. Now it will be possible for members to attend the sessions and return home by Wednesday evening for a half-week's work in their offices.

The number of general sessions will be reduced and strengthened by better organization and more guest speakers. Sectional meetings will be held during the afternoons, and each section will assist in arranging its own program to include an outstanding authority in each field as guest. With 12 sections recognized for the first year, the number of invited speakers will be increased correspondingly to provide a very strong inducement for members to attend.

Memorial Exercises will be held on Sunday, a time more fitting to the occasion. The Woman's Auxiliary will be requested to assist in arranging this program which will be held in the Academy of Medicine of the Fulton County Medical Society.

The new Convention Hall at the Biltmore Hotel has been completed and will provide excellent facilities for both technical and scientific exhibits. Over 100 booths will be available for this purpose and many new organizations have been invited to participate. All medical schools, clinical organizations, and the AMA will be invited to present exhibits.

This can easily be the biggest and best meeting yet staged by our Association and your cooperation and constructive comments are invited by the committee. Dr. Richard Torpin, Augusta, is Chairman, and your communications should be directed to him at the University Hospital, Augusta.

OUR TWENTY-FIVE DOLLARS

What Is the American Medical Association? How Does It Operate? How Are Its Activities Carried On? What Services Does It Provide?

The American Medical Association was founded in 1847, as a federation of territorial, state, and county medical societies of the United States. It is a non-profit organization devoted to raising the standard of medical practice and medical education for the protection of the public welfare and for the improvement of the health of America. It has many activities of which the average physician may not be aware. These valuable functions are very important to every physician and affect practically all Americans.

The AMA general headquarters are at 535 North Dearborn Street, Chicago, but the offices of each state or county medical society are an integral part of the framework of the Association. The general headquarters are housed in a nine-story building, owned and managed by the American Medical Association. More than 850 full-time employees are needed to carry on its business. These functions are under the supervision of a general manager, Dr. George F. Lull, a former major general and deputy surgeon general of the U. S. Army.

The Association owns and operates its own printing presses. From these presses come 167,000 copies weekly of *The Journal of the AMA*. There are nine specialty journals printed monthly, including *Today's Health* (formerly called *Hygeia*), which is the most widely quoted layman's health magazine in the world with 250,000 copies distributed each month. Other specialty journals are the AMA Archives of Internal Medicine, Archives of Ophthalmology, Archives of Pathology, American Journal of Diseases of Children, Archives of Surgery, Archives of Industrial Hygiene and Occupational Medicine, Archives of Otolaryngology, and Archives of Neurology and Psychiatry. The Index Medicus, a quarterly compilation of all new books and articles in the field of medicine with an index by author and subject of more than 1100 foreign and domestic medical periodicals, is another important service of the Association. The *American Medical Directory* lists 219,677 physicians, noting age, year of graduation, where licensed to practice and specialty of each. It contains other valuable information on medical subjects. Thousands of pamphlets, circulars, and posters on health aspects are printed yearly for distribution.

The House of Delegates is the legislative body which establishes the policies of the AMA. The delegates are selected by the state medical societies and by the Sections of the Scientific Assembly. Representatives from the Surgeon-Generals staff of the Army, Navy, Air Force, U. S. Public Health Service, and Veterans Administration are also seated as delegates. The number of delegates from the constituent associations is

proportional to the number of active dues-paying members of the respective societies. And one delegate is allotted for each 1000 active members or fraction thereof. The delegates meet at least twice yearly and at other times when necessary to carry on the work of the Association. The House of Delegates elects all Association officers, the Board of Trustees, and the Judicial Council.

The Student American Medical Association was organized in December, 1950, at the Cleveland meeting, where 47 medical schools were represented. This organization of medical students is under the direct supervision of the Board of Trustees, but it has its own constitution and by-laws. At the Session of the House of Delegates in Atlantic City recently three delegates from the Medical Association of Georgia were seated.

The Board of Trustees has the same powers and performs such duties as do directors of any corporation. It acts for the House of Delegates between meetings. The Board is composed of nine members elected by the House of Delegates for a period of five years each.

The following amendments to the Constitution and By-Laws of the AMA in regard to the payment of dues were approved at the Atlantic City meeting: DIVISION 1—Chapter II. Section 2. Annual dues may be prescribed for the ensuing calendar year in an amount recommended by the Board of Trustees and approved by the House of Delegates. Each active member shall pay said annual dues to the constituent association (state society) for transmittal to the Secretary of the American Medical Association.

Dues will include subscription to the Journal of the AMA.

The Board of Trustees may excuse a member from the payment of dues for the following reasons, provided he is fully or partially excused from the payment of local dues by his component and constituent association (county and state societies).

(a) Members on whom the payment of dues would work a financial hardship. This fact must be certified to by the secretary of a member's component society (county).

(b) Members retired from active practice;

(c) Interns and residents during the first five years following graduation, except that the time spent in military service may be excluded in calculating the five year limit;

(d) A member temporarily in the Armed Forces. Dues will be remitted and prorated January 1 or July 1 following the date of the member's entrance into military service.

(e) Members over 70 years of age may be excused on request from the payment of American Medical Association dues, regardless of local dues exemptions.

The officers of the American Medical Association are: President—Dr. John W. Cline of San Francisco, Calif.; President Elect—Dr. Louis H. Bauer of Hempstead, N. Y.; Vice-President—Dr. Oscar B. Hunter of Washington, D. C.; Secretary and General Manager—Dr. George F. Lull of Chicago, Ill.; Treasurer—Dr. J. J. Moore of Chicago, Ill. Speaker of the House of Delegates—Dr. F. F. Borzell of Philadelphia, Pa.; Vice-Speaker of the House of Delegates—Dr. James R. Rueling of Bayside, N. Y.; Chairman of the Board of Trustees—Dr. Dwight H. Murray of Napa, Calif.

EUSTACE A. ALLEN, M.D.

(This is the first of a series of articles on activities of the American Medical Association to appear in *The Journal*.—Ed.)

WORRIES OF A COUNCILOR

If anyone took time to study the duties of the various officers of the Association, he would immediately find that a tremendous load falls on the shoulders of each Councilor. In another section of this issue of *THE JOURNAL* will be found some tangible evidence of the woes and worries involved when the Annual Reports were made during the session in Augusta.

In making the report for the First District, its representative states with exceptional frankness that his "district has been dead for the past years," and that he "does not exactly know the reason." No interest in meetings, a decline in membership of over 10 per cent, and other troubles beset him. A Councilor from another district states that "meetings have been weak with poor attendance," the next states that "things are dragging in his district," and another finds things "not doing so well."

Summing up membership figures, Councilors from five districts (50 per cent) reported a loss in totals for the year, even though a larger number of physicians was practicing in the state than in many years. When one attempts to find a reason for this, it is not easy when he considers that organized medicine throughout all branches of its organization is getting quite a bargain for the amount of dues charged. Likewise compared with other states, dues in Georgia are lower than those in 42 other states.

Some society secretaries have found difficulty in arranging programs far enough in advance to receive adequate publicity. However, your Association is now able to give real assistance at any time. Many organizations in the State, such as the Georgia Heart Association, the Georgia Chapter of the American College of Surgeons, and the Georgia Division of the American Cancer Society have panels of excellent speakers to supply such needs, together with the necessary funds to cover the expenses. Our new lithographing machine can be used to advantage in printing programs, the mailing of which is an easy problem with our addressograph lists already set up by districts. Finally, THE JOURNAL will give full publicity well in advance of the meeting date provided secretaries will supply it promptly.

All reports were not as discouraging. There was much to make Councilors proud of their work. The Tenth District reported its best year with a membership increase of over 40 per cent, modestly attributed to the efficiency of a new secretary. The total number of members paying AMA dues was encouragingly high, despite the confusion that surrounded the collection of this sum.

The Fourth District meets quarterly, experiencing no difficulty in arranging good programs that frequently. Any district may have meetings as often as desired, as no maximum is specified in the Constitution. A minimum of two should be adhered to rigidly, however.

Members can make the duties of their Councils much easier and more pleasant by activity in the right direction: Invite new physicians to become members and attend both your county and district societies, pay

all dues including the AMA promptly, present papers and participate in the discussions of your society, and be a good citizen in your community as well as a respected and efficient physician. Not too large an order, but that is what it takes.

THE WORLD MEDICAL ASSOCIATION

Doctors of Georgia are now being given the opportunity to take part in the work of the World Medical Association. Four years old, it is already a success, producing fellowship and a community of interest not only among doctors, but among the peoples of our world.

Our American Medical Association and the national medical societies of almost all countries outside the iron curtain, have joined to bring to all peoples the highest possible health level and to promote peace among them. Medicine knows no national boundries. Isolationism has no part in our profession.

To further the aims of our Association, we must have the interest, support, and active participation of physicians all over the world. You and I, as individuals and members of organized medicine, must participate in this work.

Some of us have been members of the United States Committee from its beginning in 1947. We now invite all doctors in Georgia to join us. You, as members, will receive a certificate of membership, the World Medical Association bulletin, and its other publications, and, if you desire, letters of introduction to foreign medical associations, hospitals, clinics, and to doctors.

You will also have the privilege of attending general assemblies of the World Medical Association as an accredited observer from the United States Committee.

For the first time, you and I have the opportunity to take part in protecting the freedom of medicine throughout the world and to assist in raising standards of medical education, research, and patient care. It is satisfaction to realize that we are helping to produce good feeling toward our country and to build peace among nations.

(Continued on Page 366)

PR NEWS LETTER

PUBLIC RELATIONS DEPT., MEDICAL ASSOCIATION OF GEORGIA, 875 W. PEACHTREE N. E., ATLANTA, GA.

Volume I, No. 7

August 1951

Dear Doctor:

In assessing the PR-program of the Medical Association of Georgia, probably the most important aspect to be reviewed at this time is the progress made toward improving everyday relations between our Association and Georgia press and radio representatives.

In the interim since the *First Annual Medical Press and Radio Conference* last October, a careful analysis of news items supplied our offices by state clipping bureaus would indicate a decided step in the right direction by the Association, doubtlessly traceable to last year's Conference. Not only does it appear that state-wide medical press coverage has increased, but the over-all tone of editorials evidences a more understandable grasp of our objectives on the part of state newspapers and radio representatives.

The adoption this year of a press and radio code of cooperation by Fulton County Medical Society has demonstrated the advisability of such action by other county societies. Aware of the Fulton County members specified to furnish and verify medical information, Atlanta press and radio representatives are greatly facilitated in their reporting. They are made happy by their ability to get accurate information in adequate time for deadlines. Fulton County doctors, in turn, are pleased by the resultant good medical coverage.

The recommendation by the Public Relations Committee that all county medical societies of the Association adopt codes of cooperation with the press and radio received official approval at the Annual Session in Augusta last April.

To date, too few of our county medical societies have adopted such codes with their local press and radio sources. The county medical society which is striving to develop a public relations program should remember that its role, like that of the individual physicians who compose its membership, is to be of service to the people it serves. Because it is an organized body, the county medical society which adopts a code of cooperation can at once act in the best interest of an entire community. Matters of public health and preventive medicine are well within its province and sphere of action. Indeed, if any county medical society ignores or shuns its broad duty to the people, it does not then fulfill its most important obligation.

The Public Relations Committee of the Medical Association of Georgia has recognized that any progress made to date on medical press relations represents mere "surface-scratching." For that reason, it already has scheduled the *Second Annual Medical Press and Radio Conference* for Friday evening, October 26, at Macon. Program plans for the Conference, at this writing, remain indefinite. However, the importance of active participation in the conference by every county medical society in Georgia deserves reiteration, even now.

Georgia press and radio editors have demonstrated their willingness and ability to cooperate with Georgia physicians. May our members continue to do likewise with them.

SID WRIGHTSMAN, JR.,
Executive Secretary and
Public Relations Director

ORGANIZATION SECTION

Abstract of Meetings of Council, Annual Session of the Medical Association of Georgia, Augusta, April 17-20, 1951

(Pertinent information only has been included in this report.—Ed.)

First Session—Tuesday, April 17, 4:45 P.M.

Chairman W. G. Elliott presiding.

All members present except Dr. Lee Howard, First District and Vice-Councilor, Dr. Charles T. Brown; Dr. Charley Wall, Thomasville, Second District, and Vice-Councilor, Dr. C. H. Watt; Dr. H. Dawson Allen, and Vice-Councilor, Dr. H. G. Weaver, Sixth District; Dr. Lloyd Wood, and Vice-Councilor, Dr. M. M. Hagood, Seventh District. Drs. Wall and Wood came in during the session. Also Vice-President, T. A. Peterson, Savannah, represented the First District.

The following actions were taken:

1. The old Committee on Medical Preparedness was dissolved.
2. The following reports of membership by Districts were made:

a. First District—Dr. T. A. Peterson, Savannah: Frankly, the First District seems to have been dead for the past year. I do not know exactly why. We have always had very good meetings twice a year, but this past year we have not had any meetings. According to this report, there is a loss of members during the year from 170 to 149. Most of that loss is attributable to young men going into the service.

b. Second District—Secretary Shanks: The Second District one year ago had 154 members, and this year they have 158; 82 of the 158 members have paid their AMA dues, so the record is very good throughout that District. Except for one, Mitchell county, the record is better than for last year. Mitchell county so far has fallen short by three members.

c. Third District—Dr. W. G. Elliott, Cuthbert: In April, 1950, we had 140 members and this year we have 164, which is a slight increase. Some of the societies have remained the same, and one or two have decreased. The Muscogee County Society has increased considerably. We have had two District Society meetings during the past year. One of them was very well attended. The last one, held in Columbus last fall before Christmas, was not very well attended; but we had other very good meetings. Out of the 164 members that have paid this year, 135 have paid to the AMA also.

d. Fourth District—Dr. J. W. Chambers, LaGrange: The Fourth District has a total paid membership of 125, as against 129 a year ago.

That can be accounted for mainly by loss to the services; ill health, and inactive members. The loss primarily in Spalding and Troup Counties. The other counties have had perhaps a one or two member increase. Troup County has lost three men, one by transfer to the State of Alabama for practice, one to the military service, and another who moved across the Alabama line, although he still practices in the community of West Point and vicinity. We have a total paid membership of 95 to the AMA out of the 125, and I hope before the year is out we will be able to increase that number materially.

The District Society meetings have been four in number since the last annual meeting of the Association. Those meetings were distributed between the communities of LaGrange, Thomaston, Griffin and Newnan. The meetings were very well attended, and provided considerable scientific stimulation to the membership of the District. I believe as a whole the Fourth District is doing well at the moment.

e. Fifth District—Dr. Marion C. Pruitt, Atlanta: The Fifth District has had a very active year. We have had one very good meeting. I think as a whole our District has had probably more activity than in any other year. Some of our members have not paid up as well as they did in previous years. This is easy to explain, because in trying to collect the \$25.00 AMA dues, we sort of made it mandatory, and I imagine that will make a difference in all of the districts. We have not as many members paid up this year as we had this time last year. We have 509 paid members and nine associate members so far, or a total of 518 reported to date.

f. Sixth District—Dr. H. Dawson Allen, Milledgeville: The Sixth District has had a very active year. We have had two good District meetings. We show a total membership of 171 as against 162 last year. We have 99 who have paid AMA dues. I do not believe any of the counties have felt that the AMA dues were mandatory, and for that reason we probably have not pushed this as much as we should. We have a total gain in membership of nine, and have six associate members and eight honorary members.

g. Seventh District—Secretary Shanks: The Seventh District record shows 162 members this year against 170 last year. We are short a few members there. We have had several deaths in that area.

h. Eighth District—Dr. Sage Harper, Douglas: The Eighth District is doing fairly well without much assistance from me. My home county is the weakest society in the District. I cannot do anything about it because the boys are too close to home. Our paid membership is 121. The total membership is 133 now, as against 135 last year. One or two dropped out. I think they went into the Army and were not interested enough to even mention their membership. There are 97 in the District who have paid their AMA dues, which I consider very good. There are three county societies in the District that are doing good work; the rest of us are simply dragging. Our salvation seems to be in our District meetings. We had a weak meeting in October. The spring meeting was held in Waycross. It was very well attended, and we had a good program. The last three or four District meetings we have had a lay speaker. We had a lawyer who spoke to us on medical-legal aspects; an income tax expert on another program, and the last time we had a minister. As a whole, the Eighth District is doing fairly well.

i. Ninth District—Dr. Bruce Schaefer, Toccoa: The Ninth District is not doing so well as far as the doctors are concerned. Either they are moving away or dying off. Last year we had 98 members and this year we have only 85, with 77 paid members. We have lost two doctors in our section of the country, one who moved to Aiken, S. C., which leaves Rabun County with just one doctor; and Banks County also has only one doctor. Dr. Dover at Clayton is 75 years old, and Dr. Jolley of Homer is about the same age. Both of them are doing mighty good work, and it is a terrific strain climbing over those hills and doing the type of practice they have to do. We still have a good many doctors who are active but very old, and that accounts for our low number who have paid to the AMA. We show 59 out of 77 who have paid, which is a good percentage; but there are a good many who do not want to become honorary members and who want to keep an office and have a place to go. They do a little practice. They do not feel that their practice is sufficient for them to pay the \$25.00 to the AMA; but they are keeping up their dues. Our Ninth District Society is very active. We held our fall meeting in Gainesville, with about 50 members attending. We had a good scientific and social program. Our meeting this year was not held before the State meeting, due to the fact that John Burns and I are going to entertain the Ninth District with a program at Lakemont.

j. Tenth District—Dr. H. L. Cheves, Union Point: The Tenth District has had two meetings since the 1950 State meeting. The summer

meeting was held in Madison, with a very good program and attendance. The winter meeting was held in Augusta, and, as usual, they had an excellent program. We had a considerable increase this year over last year as far as total membership is concerned. We had 217 as against 149, which was due largely to the active Secretary, Dr. W. H. Philpot, in Richmond County, Augusta, who has been out after dues, and the members have paid them earlier this year than they usually do. One of the 217 total membership, 154 have paid their dues to the AMA. This is probably one of the best reports we have made in a long time.

3. The Report of the Committee on Medical Defense was accepted and filed.
4. A motion directing the Executive Committee to study needs of the Secretary-Treasurer's office and make report was adopted.
5. A motion to appropriate (donate) \$1,000.00 to Better Health Conference of Georgia was adopted.

Adjournment.

Second Meeting—Friday Morning, April 20, 8:10 A. M.

Chairman, Dr. W. G. Elliott, presiding.

The following actions were taken:

1. The Report of the Auditing Committee was approved (See complete financial report by Ernst & Ernst, Auditors, published in the JMAG, May issue).
2. A motion to appropriate \$600.00 to the Woman's Auxiliary was passed.
3. A motion to allot \$15,000 to Public Relations Department was passed. (Council was empowered to increase this amount if it became necessary.)

Adjournment.

First Session—New Council, Friday, April 20, 12:50 P. M.

President W. F. Reavis presided for the purpose of organization.

Actions taken were as follows:

1. Dr. W. G. Elliott was elected Chairman of Council.
2. Dr. Sage Harper was elected Vice-Chairman of Council.
3. Dr. Lloyd Wood elected as a member of the Executive Committee of Council. (Executive Committee will be composed of President Reavis, Chairman Elliott, Secretary Poer and Councilor Wood.)
4. It was moved and passed that Dr. Poer serve temporarily as Editor of *The Journal*.
5. A motion that all salaries remain the same as in previous years was passed.
6. A motion that Drs. Pruitt and Poer serve as special committee to investigate the amount of insurance coverage and bonds needed for

employees of the Association and report to first meeting of Executive Committee was passed.

7. A motion passed that Dr. Allen H. Bunce be reimbursed for cost of printing new Constitution and By-Laws.
8. A motion was passed making Dr. Steve Brown, Chairman Public Relations Committee, and Dr. C. C. Aven, Vice-Chairman of Public Policy and Legislation Committee, members of Executive Committee of the Public Relations Department (other members of this Committee are the members of the Executive Committee of Council).
9. The date for the next meeting of Council set for Sunday, May 20, at Association headquarters.

Adjournment.

MEETING OF THE COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA Abstract of Meeting of Council, Academy of Medicine, Atlanta, May 20, 1951

Chairman W. G. Elliott, presiding.

Present were Dr. W. F. Reavis, President; Dr. C. F. Holton, President-Elect; Dr. David Henry Poer, Secretary-Treasurer; Dr. Lee Howard, First District; Dr. C. K. Wall, Second District; Dr. W. G. Elliott, Third District; Dr. J. W. Chambers, Fourth District; Dr. Marion C. Pruitt, Fifth District; Dr. D. Lloyd Wood, Seventh District; Dr. Sage Harper, Eighth District; Dr. Bruce Schaefer, Ninth District; Dr. H. L. Cheves, Tenth District, and Dr. Charles R. Andrews, Jr., new Vice-Councilor of Ninth District. The Sixth District was not represented.

The following items were discussed and action taken:

1. It was voted to purchase a Fidelity Schedule Bond for Dr. David Henry Poer, Secretary-Treasurer, in the amount of \$10,000.00 on a three year basis at the cost to the Association of \$62.50, and a \$1,000.00 bond for Miss Viola Berry, secretary, on the same basis at a cost of \$6.25.
2. All motion picture projectors are to be left in the Districts to which they were assigned.
3. Drs. J. W. Chambers, Chairman, H. L. Cheves, and Bruce Schaefer were named the Committee on Audit and Appropriations.
4. A motion to pay Councilors 10 cents per mile, one way, to attend the meetings of Council was made and carried.
5. A fund of \$1,000.00 for the use of the President which includes travel was voted favorably.
6. It was voted that, if possible, additional space be obtained in the Academy of Medicine of the Fulton County Medical Society so that all offices be adjoining, and that equipment and other facilities not be duplicated.
7. It was voted that the positions of Executive Secretary and Public Relations Director be

combined, provided a suitable person can be obtained for the position.

8. Dates for the 1952 annual session were discussed. Those selected were May 11-14. Committee on Arrangements for 1952 annual session as follows: Drs. Marion C. Pruitt, Chairman; David Henry Poer and J. W. Chambers. This committee appointed Dr. James H. Semans as local chairman on arrangements (Dr. Semans had been suggested by the Fulton County Medical Society).
9. The Executive Committee of Council was designated the committee to set the prices for technical exhibits (These have been set at \$250 for each booth for the 1952 session).
10. Dr. David Henry Poer, acting temporary Editor of *The Journal* (see minutes of Council, Augusta session 1951) was appointed Editor. He was granted \$1,200.00 for the purpose of employing an assistant editor, if necessary. He was requested to suggest names to Council for the Editorial Board.
11. Medical Defense: Drs. Marion C. Pruitt, B. H. Minchew, Marcus Mashburn, Sr., W. G. Elliott and David Henry Poer were appointed as the Committee on Medical Defense, with Dr. Pruitt as chairman.
12. The current salaries of all employees, current pension, current retainer fee for attorney and current contributions (see minutes of Augusta session 1951) for Woman's Auxiliary and Better Health Council of Georgia all were approved, as was a donation of \$1,200.00 to the Fulton County Medical Society for the current fiscal Association year. Secretary Poer was authorized to pay ordinary expenses of his office as in the past.
13. The next meeting date of Council according to the new Constitution and By-Laws will fall in September.

Adjournment.

MEETING OF EXECUTIVE COMMITTEE OF COUNCIL, HOTEL DEMPSEY, MACON, JUNE 24, 1951

Present were: Dr. W. F. Reavis, President; Dr. W. G. Elliott, Chairman of Council, and Dr. David Henry Poer, Secretary-Treasurer.

1. It was voted unanimously to employ Mr. Sid Wrightsman, Jr., as Executive Secretary and Public Relations Director. His salary to be \$5,400.00 annually or \$450.00 per month. This arrangement for 90 days at which time the salary will be reconsidered (Mr. Wrightsman accepted the position).

2. Dr. W. S. Dorough, Chairman, Insurance and Economics Committee, made a report regarding the insurance plan of the Provident Life and Accident Insurance Company, in which 50 per cent of members of the Association must participate, and this was approved unanimously. The company was authorized to proceed with its plans to sell

these policies to members of the Association.

3. Dr. Dorrough requested the payment of \$1,600.00 to cover the cost of printing pamphlets for The Georgia Plan and this was approved. The majority of the booklets will be turned over to the various insurance companies for which they will pay the cost and it is estimated that at least 75 per cent of the \$1,600.00 will eventually return to the treasury.

Adjournment.

FIRST MEETING OF THE COMMITTEE ON SCIENTIFIC WORK HOTEL DEMPSEY, MACON, JUNE 24, 1951

Vice-Chairman Thomas L. Ross, Jr., Macon, presiding.

Members present were President W. F. Reavis, Thomas L. Ross, Jr., Macon, H. Ansley Seaman, Waycross, and Secretary Poer.

Invited to meet with the committee were Dr. James H. Semans, Atlanta, who had been appointed by Council as Chairman on Committee of Local Arrangements for the 1952 Annual Session in Atlanta; Dr. Paul F. Holcomb and Dr. Charles H. Hock, Augusta, who represented the Chairman, Dr. Richard Torpin, Augusta.

Dr. Hock, who participated in the program of the North Carolina Medical Society in Pinehurst, gave a report of this meeting pointing out many ways in which interest and attendance can be increased. Also a report of the Florida meeting was given, and it was noted that attendance in both states was near the 1,000 figure.

In order to improve our own meeting it was unanimously decided to make several changes in the program for the 1952 Annual Session. In general these will consist of the following:

1. The first session of the Association will be the Memorial Exercises for deceased members at 2:00 P. M. Sunday, May 11 in the Auditorium of the Academy of Medicine.
2. First session of the House of Delegates will be held at 3:00 P. M., May 11, 1952.
3. First general session of the Association will be held at 9:00 A. M., Monday, May 12. At this time nomination for officers of the Association will be made. Immediately following will be the first Scientific Session, which will be climaxed by the Address of the President at noon. The presentation of the President's Key will be made directly following, and also Lapel Buttons and Certificates of Merit to members who have practiced medicine for 50 years.
4. Beginning at 2:00 P. M. the Association will meet in Sections with programs to be arranged

for General Practice, and three other Sections. Each Section will arrange for its own guest speaker.

5. At 7:00 P. M., Monday, May 12, the Alumni and other special dinners will be held, and no further program arranged for the evening.
6. On Tuesday and Wednesday mornings general scientific sessions will again be held with guest speakers taking part. The Calhoun Lecture will be given at noon Tuesday.
7. The banquet will be held at 8:00 P. M. Tuesday evening, preceded by a refreshment hour which will be given by the new Atlanta branch of Aloe's, of which Mr. D. C. Kelley is manager. The evening will be devoted to good wholesome fun without any formal speeches. A floor show may be presented, followed by a dance.
8. On Tuesday and Wednesday afternoons, Sections will meet separately at 2:00 P. M. and each having its own guest speaker.
9. The second session of the House of Delegates will be held at 9:00 A. M. Wednesday, and the second General Session at 12:00 noon, with announcements of new officers elected.

It was voted that the Association would invite and pay the expenses of three guest speakers, and this includes the Calhoun Lectureship. Drs. Seaman and Poer were instructed to invite an outstanding surgeon, and Drs. Torpin and Ross to invite a guest. Dr. James E. Paullin was appointed as chairman of the Calhoun Lectureship and requested to invite the speaker for this occasion.

The time allotted for the presentation of each paper was 20 minutes, of which five minutes shall be reserved for closing the discussion. Each discussor shall be limited to three minutes.

Members desiring to read papers will be requested to present a short abstract for the consideration of the Committee. Essayists selected to read papers will be required to send copies to discussors not later than 30 days in advance of the annual session. Failure to comply with this rule will cause the penalty cited in the By-Laws to become effective.

Attention was directed to Chapter 11, Section 3 of the New By-Laws which states: "All papers read before the meetings shall become the property of the Association, and shall be deposited with the Secretary-Treasurer immediately after being read. Failure to comply with this and other rules set forth by the Committee on Scientific Work regarding papers, discussions and exhibits shall automatically bar scheduled participation in the scientific sessions in the future from this member for a period of not less than five years unless he presents an acceptable excuse."

(Continued on Page 366)

NEWS AND INFORMATION OF GENERAL MEDICAL INTEREST

CALENDAR

FOURTH ANNUAL POSTGRADUATE COURSE FOR GENERAL PRACTITIONERS, October 8-12, sponsored by Emory University School of Medicine and the Medical Association of Georgia. Dr. Russell H. Oppenheimer, 36 Butler St., S. E., Atlanta, Director.

OBSTETRIC SEMINAR, sponsored by Medical College of Georgia and Bureaus of Maternal and Child Health, South Carolina, Georgia and Florida State Health Departments, Sheraton-Plaza Hotel, Daytona Beach, Fla., September 10-12.

GEORGIA CHAPTER OF AMERICAN ACADEMY OF GENERAL PRACTICE, Idle Hour Country Club, Macon, October 25. Dr. Walter W. Daniel, 743 West Peachtree St., N. E., Atlanta, President.

GEORGIA DIVISION OF THE AMERICAN CANCER SOCIETY, Clinical Session, Academy of Medicine, Atlanta, September 14, 2:00 p. m. Dr. Randolph Lee Clark, Jr., Houston, Texas, guest speaker. All physicians invited.

GEORGIA CHAPTER AMERICAN COLLEGE OF SURGEONS, Bon Air Hotel, Augusta, October 18. Dr. James H. Semans, 34 7th Street, N. E., Atlanta, Acting Secretary.

GEORGIA HEART ASSOCIATION, Hotel Oglethorpe, Savannah, September 14-15. Dr. J. Frank Harris, Medical Arts Building, Atlanta, Secretary.

GEORGIA ORTHOPEDIC SOCIETY, Bon Air Hotel, Augusta, October 18. Dr. John I. Hall, 666 Cherry Street, Macon, Secretary.

GEORGIA PEDIATRIC SOCIETY, ACADEMY OF MEDICINE, Atlanta, October 11. Dr. Harry Lange, 490 Peachtree St., N. E., Atlanta, Secretary.

GEORGIA RADIOLOGICAL SOCIETY, Bon Air Hotel, Augusta, October 18. Dr. Robert Pendergrass, Americus, Secretary.

GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY, Augusta, October 18. Dr. Jule C. Neal, Jr., 203 Professional Building, Macon, Secretary.

GEORGIA STATE SOCIETY OF ANESTHESIOLOGISTS, Bon Air Hotel, Augusta, October 18. Dr. Perry Volpitto, University Hospital, Augusta, Secretary.

GEORGIA UROLOGICAL ASSOCIATION, Bon Air Hotel, Augusta, October 18. Dr. Reese C. Coleman, Jr., 490 Peachtree, Atlanta, Secretary.

INTERNATIONAL COLLEGE OF SURGEONS, United States Chapter, Palmer House, Chicago, September 10-13. Dr. William Perrin Nicolson, Jr., 478 Peachtree St., N. E., Atlanta, Regent for Georgia.

SOUTHERN MEDICAL ASSOCIATION, Dallas, Texas, November 5-8. Mr. C. P. Loran, Secretary-Manager, Empire Building, Birmingham 3, Ala.

MEETINGS

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE will hold its twenty-ninth annual scientific and clinical session September 4, 5, 6, 7 and 8, 1951, at the Shirley-Savoy Hotel, Denver, Colorado. All sessions will be open to physicians and other professional personnel. In addition to the scientific sessions, the annual instruction seminars will be held September 4, 5, 6, and 7. These seminars will be offered in two groups. One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Ill.

THE GEORGIA CHAPTER OF THE AMERICAN ACADEMY OF GENERAL PRACTICE at the Idle Hour Country Club, Macon, Thursday, October 25, with the following program: "Practical Application of the Barium Enema", Dr. Robert C. Pendergrass, Americus; "Management of Preeclampsia and Eclampsia", Dr. R. K. Hancock, Atlanta; "An Evaluation of the Clinical Importance of ACTH and Cortisone", Dr. Paul Beeson, Atlanta; "The Acute Abdomen", Dr. Philip Thorek, Chicago.

The business meeting will be held at 11:00 a. m. and Mr. Leo Brown, Director of the Department of Public Relations of the American Medical Association, will be the speaker at the noon luncheon. Luncheon reservations and inquiries regarding the meeting should be directed to Dr. Albert R. Bush, Hawkinsville.

THE SECOND INTERNATIONAL GERONTOLOGICAL CONGRESS will be held September 9-14, 1951 in St. Louis, Mo.

Designed to further knowledge in medical, social and economical problems of aging, the Second Congress is a continuation of the First, held at Liege, Belgium, June 9-12, 1950. The August, 1950 Conference on Aging in Washington, D. C., was a similar expression of the very great interest on the part of Americans in the problems of aging.

DISTRICT AND COUNTY MEDICAL SOCIETIES

Meeting Dates:

AUGUST 23: Tenth District Medical Society, Washington, 11:00 a. m.
 SEPTEMBER 6: Fulton County Medical Society, Academy of Medicine, Atlanta, 6:00 p.m.
 SEPTEMBER 18: Fourth District Medical Society, LaGrange, 7:00 p. m.
 SEPTEMBER 26: Seventh District Medical Society, Cedartown, 2:00 p. m.
 SEPTEMBER 26: Ninth District Medical Society, Jasper, 3:00 p. m.
 OCTOBER 4: Second District Medical Society, Thomasville, 3:00 p. m.
 OCTOBER 6-7: Eighth District Medical Society, King and Prince Hotel, St. Simons Island.
 DECEMBER 5: Sixth District Medical Society, Macon, 2:00 p. m.

The Fourth District Medical Society met at the Shrine Club, Thomaston, June 12. The Upson County Medical Society was host. Dr. Arthur J. Merrill, Atlanta, discussed the uses of ACTH following the showing of two scientific films on the subject.

Elbert County Medical Society, Elberton, recently held a joint meeting with trustees of the new Elberton-Elbert County Hospital for discussion on "The Georgia Plan." Officers for 1951 are Dr. Carey Alston Mickel, Jr., President; Dr. Albert Sidney Johnson, Jr., Vice-President; Dr. John B. O'Neal, III, Secretary-Treasurer, and Dr. D. N. Thompson, Delegate, all of Elberton.

Screven County Medical Society, Sylvania, was recently reorganized and held its initial meeting on June 1. The scientific program consisted of a round-table discussion of cases presented by members. The officers for 1951 are Dr. James C. Freeman, President; Dr. Katrine Rawls Hawkins, Vice-President, and Dr. William G. Simmons, Secretary-Treasurer, all of Sylvania. Dr. Freeman was elected Delegate.

CORRESPONDENCE

OFFICE OF THE GOVERNOR
ATLANTA

August 7, 1951.

Medical Association of Georgia
875 West Peachtree Street
Atlanta, Georgia

My dear Dr. Poer:

Thank you for your very interesting letter of August 3, 1951, and the copy of the letter you recently addressed to the Editor of the Atlanta Journal.

It was with much interest that I read your letter several days ago in the "Letters to the Editor" column of that newspaper. Let me express to you my grateful appreciation to you for your interest in seeing that these facts are published in a clearer light.

We are making rapid strides in this state with our Hill-Burton program. I am confident that the work which we have already done is only the beginning. You may be assured that so long as I am Chief Executive, we will continue to exert every possible effort to create more and better health facilities.

Please call on me whenever I can be of service to you or the Medical Association of Georgia.

With kindest regards and all good wishes, I am

Sincerely yours,

HERMAN TALMADGE.

MILITARY

ARMY INDUCTS FIRST PHYSICIANS UNDER DOCTOR-DRAFT LAW. Army reports drafting of two physicians as privates—the first under the doctor-draft law. Dr. Stanley J. Orloff of New York City and Dr. Robert Beconovich of Hammond, Ind. Private Beconovich, a 27-year-old father of two children, reported at Fort Sheridan recently and began earning his \$75 monthly private's pay. As an officer he would have been entitled to about \$400 a month plus a \$100 bonus for signing up.

Army earlier reported marked increases in Priority I men seeking commissions. In asking Selective Service to delay August call, Defense Department emphasized its request was based only on the increase in rate of volunteers and not on any reduction of requirements for medical officers. There is no anticipated reduction in the September call of 152 Priority I physicians, but it's possible that Defense will ask for more men in event the August quota is not filled.

CAPT. LARRY BREGMAN, Atlanta, MC, is chief of pediatrics at Camp Stewart, Ga.

LT. GUY L. CALK, Augusta, Air Force Medical Corps, is on duty at Robins Field, Ga.

DR. BERNARD TEPPER, Cordele, is awaiting orders to report for military service.

CLINICAL INFORMATION

Sunburn May Be More Than Skin Deep, Dermatologist Warns

Sunburn may be more than skin deep, a Pittsburgh dermatologist warned in an article in the current issue of *Today's Health*.

Besides the immediate skin burn and possible infection resulting from excessive exposure to the sun, there may be consequences after a lapse of months to a year, according to Dr. Lester Hollander.

One disease, known as xeroderma pigmentosum but a rarity, is marked by roughness and dryness of the skin. At first these are unduly deep-hued; later they form ulcers and the skin around them forms highly malignant cancers. Sunlight accelerates these changes.

A second, and another infrequent disease, is disseminated lupus erythematosus, which affects the skin. The disease includes a residual dermatitis (at the site of a sunburn, as a rule), leukopenia (lowering of the white cell content of the blood), loss of supporting connective tissue in the internal organs and a gradual and persistent general weakness.

Thirdly, there are many reports to indicate that the sun plays a provocative role in the development of skin cancer, which is found more often in people who work outdoors and under the sun, like farmers.

Korean Wounded Has Better Chance Than Victim of Civilian Accident

A wounded member of the United Nations in Korea entering a military hospital has a better chance of survival than a civilian accident victim who is taken to a large municipal hospital, in the opinion of Major General Edgar Erskine Hume, chief medical officer of the United Nations Forces in Korea.

Deaths among hospitalized service men in Korea have run at about half of the record low rate in World War II. In that war, about 955 out of every 1,000 men brought to a military hospital lived, whereas the Korean survival rate has risen to 975, he said.

"Municipal hospitals in large cities, those that care for the victims of ordinary accidents due to traffic, industry and the like, can hardly match these figures," he added.

Summer Is the Time for Hobbys

Edward L. Bortz, M.D., Philadelphia, past president of the American Medical Association, states in his paper, "The Elderly Patient" published in the June issue of the *Michigan Medical Journal*:

"Never retire. Never retire to a life of complete inactivity. It is far more desirable to wear out than to rust out. By the development of new pursuits when one is asked to withdraw from a faculty, a bank, an industry, or other occupation, one can make a wise investment in his new found leisure."

During the summer months a wise investment in leisure, a wise investment in activities other than medicine, will pay dividends at the other end of the road.

New Dye Measures Blood Volume

A clinically-proven dye to guide doctors in administering blood transfusions soon will be produced for the first time in a form for therapeutic use for general distribution to the medical profession, it was announced recently by Elmer H. Bobst, president of Warner-Hudnut, Inc. Known as Evans Blue Dye, this formula acts as a guide for measuring a patient's circulating blood volume and also used experimentally to determine the efficiency of the heart and to help spot abnormal openings between its various chambers.

This dye also has been employed in evaluating "blood substitutes" and in investigating the permeability of various tissues as a result of drug action. Other uses are tracing the spread of certain infections, recording the degree of the blood's oxygenation, determining circulation time and cardiac output, and localizing abscesses and malignant growths.

The prime advantage in using Evans Blue Dye to measure circulating blood volume is that it combines chemically with blood plasma without harming the body and travels through the body with the plasma.

Clinical reports have indicated an absence of ill effects in connection with the use of the dye.

Breon Makes Research Grant For Studies of Bile Acids

George A. Breon & Company has awarded another grant to the University of Kansas City's College of Pharmacy, to finance research for one year on the basic physiologic and pharmacologic action of bile acids, it was announced jointly by Dr. Clyde W. Geiter, medical director of the company, and Dr. T. T. Dittrich, dean of the college.

Few basic studies of bile acid have thus far been undertaken, Dr. Geiter explained. Medical science does not yet know exactly what bile acids do in the liver. Desoxycholic acid, one of the bile acids, recently gained prominence when cortisone was developed synthetically from it.

Scientists will also look for the relationship of the bile acids to the steroid hormones, such as testosterone and estrogen.

They will also try to determine whether administration of bile acid raises or lowers the oxygen requirements of the liver cells, a study which may produce valuable information concerning certain pathologic conditions of the liver.

Parke-Davis to Replace Flood-Damaged Drugs

Medicines destroyed or damaged by flood in Missouri, Kansas and Oklahoma drug stores to be replaced without charge by Parke, Davis Company.

Health Authority Sees Amebiasis Spreading

Despite good environmental sanitation programs in large cities, amebiasis, a parasitic infection often transmitted by foodhandlers including workers and housewives, may be spreading, according to Dr. Howard B. Shookhoff, of New York City Health Department, in the Bulletin of the New York Academy of Medicine.

Amebiasis ranks second today only to malaria among the world's most widespread protozoan infections, and may actually be spreading.

In acute amebic dysentery caused by the parasite, symptoms may include muscular pain and weakness, mental depression, loss of weight, anemia, emaciation and severe diarrhea. In approximately five per cent of all cases, serious liver complications called amebic hepatitis develop. The newer antibiotics sometimes fail to destroy the amebae, he reported, and Aralen is required for effective treatment of cases of hepatitis and especially liver abscess, sometimes fatal. Developed by Winthrop-Stearns, Aralen is chemically chloroquine diphosphate; increasingly used in many parts of the world as a potent anti-malarial.

Obesity Great Medical Danger

Forty thousand fat people in Atlanta have less-than-average chances of living long, disease-free lives.

Atlanta doctors agree that "Fatty" is not a laughing matter.

They point to scientific studies which prove, in effect:

"The longer the waistline, the shorter the life-line."

One research project indicated:

Of ten 30-year-old fat men, six will survive to 60, three to 70 and perhaps one to 80. But of ten 30-year-old lean men, eight will live to 60, five to 70 and three to 80.

Dr. J. C. McLoughlin, chairman of the committee on standards, Fulton County Medical Society, reported the recent Greater Atlanta Health Survey showed 7.2 per cent of those tested here were 25 per cent or more overweight.

At that rate, he said, 40,000 people in the area weigh 25 per cent more than they should. Thousands of others are 10 per cent or more overweight.

Obesity and Diabetes

Dr. James E. Paullin, chairman of the Georgia chapter, American Diabetes Association, and Dr. J. Gordon Barrow, secretary of the Georgia Heart Association, point out that obesity is often a dangerous factor in heart disease and diabetes.

"Every pound of fat must have three miles of blood vessels to supply it with blood. . . . Each pound puts an added strain on the heart."

Statistical studies also have demonstrated adverse effects of obesity on kidney disease, arthritis, pulmonary emphysema and other maladies. And excess fat increases the dangers of surgical procedures and obstetrical deliveries.

MEDICAL COLLEGES AND DEPARTMENT OF PUBLIC HEALTH

A COURSE IN ELECTROCARDIOGRAPHY, sponsored by the American College of Physicians, will be given at Emory University School of Medicine, Atlanta, October 29-November 2, under the direction of Dr. R. Bruce Logue of Atlanta and Dr. Robert P. Grant of Bethesda, Md.

Minimal registration will be 25 and maximal, 75. The fee will be \$30 for members of the American College of Physicians and \$60 for non-members.

Instructors will include Dr. R. H. Bayley, F.A.C.P., Professor of Medicine, University of Oklahoma School of Medicine, Oklahoma City, Okla.; Dr. Robert P. Grant, National Heart Institute, Bethesda, Md.; Dr. R. Bruce Logue, F.A.C.P., Emory University; Dr. J. Gordon Barrow, Grady Memorial Hospital, Atlanta, and Dr. Joseph H. Doyle, Instructor in Physiology and Assistant in Medicine, Emory University.

The course is designed for those with previous experience in electrocardiography. It will encompass the presentation of the basic concepts of electrocardiography including: (1) Physics of depolarization and repolarization; (2) the relationship of unipolar, bipolar and precordial leads; (3) the vectorial concept of electrocardiography, including a description of the method used to determine the direction of electrical force in space from simple inspection of routine leads; (4) the normal range and the electrocardiographic abnormalities of disease; (5) disturbances of A-V conduction and cardiac arrhythmias; (6) the influence of drugs and of electrolyte disturbances on the electrocardiogram, and (7) ample time allowed for group discussion each day.

A detailed copy of the program may be obtained on request from the directors.

DR. BITHEL WALL has been appointed *Assistant Professor of Urology*, Medical College of Georgia, Augusta, effective July 1. Dr. Wall served his internship at the Grady Memorial Hospital in Atlanta and served as Captain in the U. S. Army Medical Corps until June, 1949, during which time he was a physician on the urological service at Oliver General Hospital at Augusta. Since his release from active duty, Dr. Wall has been a resident in urology at the Barnes Hospital, St. Louis, Mo. He has now returned to Augusta to join the teaching staff of the medical school from which he graduated in 1946.

DR. CURTIS HAROLD CARTER has accepted an appointment as *Assistant Professor of Medicine*, Medical College of Georgia, Augusta, effective July 1. Dr. Carter received his doctor of medicine degree from the Medical College of Georgia in 1938. After a year's internship at the University Hospital, Dr. Carter was affiliated with the Veterans Administration in psychiatry. After approxi-

mately seven years service in the U. S. Navy he was released with the rank of Commander and returned to Augusta to accept a three-year residency in medicine at the University Hospital. In 1950 he moved to Houston, Texas, for a year's participation in cancer research at the M. D. Anderson Hospital. Dr. and Mrs. Carter, the former Miss Sara Milligan, daughter of Dr. and Mrs. King Milligan, Augusta, and their four children are now residing in Augusta.

EMORY UNIVERSITY SCHOOL OF MEDICINE recently announced the following promotions on its teaching staff: Dr. Alvin G. Foraker and Dr. Abner Golden, both of Atlanta, from assistants to associate professors; Dr. Philip Bondy, Atlanta, from associate in medicine to assistant professor of medicine, and Dr. James F. Olley, Atlanta, from associate in pathology to assistant professor of pathology.

GEORGIA VD CLINICS. The recent "Directory of Venereal Disease Clinics," issued by the Public Health Service, indicates that there are presently 155 public venereal disease clinics in Georgia.

Of 2,267 such clinics in the United States and its territories, Georgia stands third, preceded by North Carolina with 222 clinics and Mississippi with 176.

The directory also shows that 42 states have prenatal laws requiring blood tests and 41 states have premarital laws requiring blood tests and physical examinations for venereal disease.

The 157-page directory carries summaries of prenatal and premarital laws, names and addresses of each diagnostic and treatment facility, laboratory facilities of each State, lists of Marine hospitals and facilities for American seamen.

Note to all County and District Society Secretaries:

A revised catalog of motion pictures available through the Committee on Medical Motion Pictures is now available. Copies will be sent to county and district medical society secretaries upon request. This catalog lists 62 16mm. films, most of which are at the professional level. Fourteen of these films are suitable for showing to lay groups. Copies are available upon request from the Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. (The exact time required for the showing of any film, regardless of interest, should be known definitely before its use on your program. Many meetings have been ruined by devoting excessive time to the showing of films and squeezing out of scheduled speakers. Better be generous and add time for handling by willing, but inexperienced medical operator—Ed.)

HOSPITALS

Macon doctors and civic leaders discussed at length their hospital needs at a recent meeting, but came to no definite conclusion. The argument centered around the advisability of constructing a 300-bed addition to the MACON HOSPITAL on its present site or on an entirely new site not in the congested district.

Physicians attending the meeting were Drs. Ralph G. Newton, Thomas Harrold, C. Hall Farmer, Thomas L. Ross, Jr., Charles N. Wasden and Jerry P. Woodhall, all of Macon. Dr. Harrold was named a member of a citizens-doctors committee to help solve the problem.

CITY HOSPITAL, Columbus, recently inaugurated its first interne training program with ten June graduates of the Medical College of Georgia participating. City Hospital received AMA-approval for interne training in December, 1950. Improvements in the hospital's medical records library, in autopsy rate and in hospital equipment, plus the affiliation with Emory University School of Medicine were necessary for AMA-approval of the program. Dr. J. A. Thrash, Columbus, is hospital director.

Savannah goes to work for a MUNICIPAL HOSPITAL. According to reports appearing in both the *Morning News* and *Evening Press*, a special meeting was called at Savannah on July 10 by the Health and Hospital Section of the United Community Services for such consideration.

Walker-Catoosa-Dade Medical Society was recently paid editorial tribute in the *Catoosa County Record* for its work in behalf of the new 100-bed TRI-COUNTY HOSPITAL, Fort Oglethorpe, contract for the building of which will be let shortly. The hospital is being built at an estimated cost of \$1,000,000. (Note progress in this case, an example of combined county effort to secure an adequate and efficient hospital.—Ed.)

MITCHELL COUNTY HOSPITAL, Camilla, recently announced its application for recognition by the American College of Surgeons. Although operating in accordance with ACS standards for a long period, the hospital must continue for eighteen additional months before official rating will be given. (For its rating the American College of Surgeons requires of a hospital the highest ethical standards, a maximum of competent service to patients and continuous research work—Ed.)

ST. MARY'S HOSPITAL, Athens, has recently inaugurated a rotating internship program.

Dr. C. W. Whitworth, Gainesville, was recently named secretary-treasurer on the medical staff of HALL COUNTY HOSPITAL, Gainesville.

GRADY MEMORIAL HOSPITAL, Atlanta, is now training medical technologists in its clinical pathology laboratory. To date, the laboratory has been turning out technologists at the rate of 15 to 16 a year. Students accepted for training in the laboratory must have had four years of college work. After finishing the required course, they are eligible for national registry examinations.

The late Dr. B. C. Adams of Thomaston was recently honored by Upson County in the dedication to his memory of the new obstetrical section of the UPSON COUNTY HOSPITAL.

WASHINGTON NEWS

THIRTY-EIGHT GOVERNORS HEARD FROM IN MURRAY POLL ON PHYSICIAN DISTRIBUTION. Thirty-eight state governors have replied to request of Chairman Murray for information on physician distribution within each state. It is understood that a majority of replies so far received indicate *no mal-distribution of physicians*.

In his letters to governors, Senator Murray said "it has been proposed that federal subsidies be used to persuade doctors to move to areas where there is an acute shortage of medical personnel." Among questions asked was "has your state too many, not enough or just about enough doctors to meet the needs of residents."

CHILDREN'S BUREAU ANNOUNCES \$83,740 EPILEPSY RESEARCH PROGRAM. Training in latest methods of treating *epilepsy* will start soon at the University of Illinois for physicians, public health nurses, medical social workers and technicians in electro-encephalography. Children's Bureau-State-University project calls for \$34,500 of federal funds and \$49,240 from the University.

GOVERNMENT SPENDING IN JUNE. During the month of June the government agencies were on a spending spree. Money not spent by the end of the fiscal year on June 30, reverted back to the Treasury. It has been estimated that the spending during June was at the fantastic rate of \$150 million an hour. The representatives of the various agencies rarely come before the Appropriations Committee with suggestion where savings can be made. But occasions are innumerable where they seek a larger appropriation than that provided in the previous year.

—Les Arends "*Inside News of Congress*."

AMERICAN LEGION SUPPORTS S. 337. U. S. Senators are being deluged in telegrams and letters from American Legion members urging passage of S. 337, the federal aid to medical education legislation. The Legion's all-out campaign for the bill is said to be deeply impressing the Senate.

GEORGIA PRESS COMMENTS

The *Athens Banner-Herald*, *Columbus Ledger*, *Savannah Morning News*, *Augusta Chronicle* and the *Atlanta Journal* carried lengthy stories recently about the "fly-by-night" fake doctor who set-up shop in Gray and did a thriving medical business until Dan Eden, *Jones County News* editor, became suspicious and started an investigation.

This absurd situation could be duplicated almost anywhere in Georgia and indicates a weakness in our present laws which are inadequate to prevent such practices.

The attention of the Legislation Committee of our Association has been called to the situation. It has scheduled a meeting in September to discuss this and other matters. (See Editorial).

Jack Tarver's remarkable article, "A Letter from a Georgia Doctor," published first in the *Atlanta Constitution* last month, continues to be reprinted in Georgia newspapers. This is "must" reading for you and well deserves reprinting for distribution to our patients.

The *Talbotton New Era*, *Spalding County Times*, *Wheeler County Eagle*, *Glennville Sentinel*, *Campbell News*, *Manchester Mercury* and *Fayetteville Enterprise* commented on the plan to provide more and better nursing care by Dr. Howard Jensen of Duke University's Department of Sociology, as presented recently before a regional conference of nurse educators at Emory University. Dr. Jensen's plan urges training of (1) practical nurses to give ordinary bedside care to persons with chronic or long-term illness; (2) registered or graduate nurses to care for persons with acute illness; (3) college graduate nurses to serve in administrative posts and the field of public health, and (4) nurses with postgraduate training to serve as teachers and to help carry on research.

Comptroller General Zack D. Cravey's letter to the press on "Rural Doctors Needed in the State" was published by the *Waycross Journal-Herald* and the *Albany Herald*. He cites the existing need for physicians in some Georgia counties, emphasizing action taken in Illinois and Mississippi to remedy the situation. It would seem that our own Association should take steps now to help rural areas obtain the necessary number of doctors.

CORRECTION: Dr. J. H. Hilsman announces the removal of his offices to 104 Ponce de Leon Ave., N. E., Atlanta. Internal medicine (gastroenterology).

Dr. George A. Holloway and Dr. John P. Barnes announce the removal of their offices from 33 Ponce de Leon Ave., N. E., to 756 Cypress Street, N. E. (between the Peachtrees at Fourth), Atlanta.

PERSONALS

DR. MCALPIN ARNOLD, Elberton, announces the opening of his office. He received his medical degree from George Washington University School of Medicine, Washington, D. C. He served as an interne in Union Memorial Hospital, then spent a year in the navy and another year of surgical residency training at Union Memorial Hospital, Baltimore.

DR. RAFF BANKS, JR. of Gainesville is doing special work in urology at the New York Hospital. He will return to Gainesville October 1 to re-open his office for the practice of urology.

Drs. Needham B. Bateman, Harold A. Ferris and Ernest A. Dunbar, Jr. recently announced the association of DR. EDMOND W. GREEN in their offices at 526 Candler Building, Atlanta.

DR. EUGENE D. BELL announces the opening of his office in Adel. His office will be located with that of Dr. Fred Clements. He received his education at the University of Georgia in Athens and Medical College of Georgia in Augusta. He interned at Norfolk, Va.

Dr. Lee Bivings announces the association of DR. THOMAS C. MCPHERSON in the practice of pediatrics, 20 Fourth Street, N. W., Atlanta.

DR. GEORGE H. BOYD, JR. announces the opening of his office for the practice of medicine on Savannah Street, Clayton.

DR. WILLARD P. CARSON, formerly of Dalton, has left his practice of medicine in Chatsworth to report at Fort Sam Houston, San Antonio, Texas to begin his duties as a first lieutenant in the Army Medical Corps. While in service his practice will be carried on by his brother, Dr. Harold Carson.

DR. AUGUSTIN S. CARSWELL announces the opening of his office for the practice of orthopedic surgery in the Southern Finance Building, Augusta.

DRS. WILLIAM G. and MIRIAM W. CHAMBLESS will begin practice of medicine in the clinic in Hamilton. Dr. Evelyn Vail Coonrad of Warm Springs has kept the clinic open for the past few months.

DR. REMER Y. CLARK announces the opening of his office for the practice of medicine at 206 Roswell Street, Marietta. He graduated from the Medical College of Georgia, Augusta.

Dr. Olin S. Cofer and Dr. Albert L. Evans announce the association of DR. HUGH H. GREGORY in the practice of surgery and gynecology at 1110 Doctors Building, Atlanta.

DRS. ROBERT B. GREENBLATT of Augusta, WALTER W. DANIEL and JOHN INMAN of Atlanta are scheduled to appear on the program of the Sixteenth Annual Assembly of the United States and Canadian Chapters of the International College of Surgeons which meets at the Palmer House in Chicago, September 10, 11, 12 and 13, 1951. Dr. Greenblatt will present a paper on "Clinical Application of Vulvar Fluorescence" on September 11 and Drs. Daniel and Inman will present a paper on "Rupture of the Pregnant Uterus" on September 12.

DR. LAWTON Q. HAIR has recently entered into the practice of internal medicine, with offices at 107 Macartan Street, Augusta.

DR. GEORGE T. HENRY announces the opening of his office at Lee and Taylor Streets, Bainbridge.

DR. JOSEPH L. KURTZ announces the opening of his office at 663 West Peachtree Street, N. E., Atlanta. Practice limited to orthopedic surgery.

DR. JOSEPH D. McELROY, Atlanta psychiatrist, announces that he will be at St. Elizabeth's Hospital, Washington, D. C., for further training from September 1, 1951 to March 1, 1952. During his absence his offices will be maintained at 490 Peachtree St., N. E., Atlanta.

DR. B. F. RILEY of Thomson recently attended a two-week session of the Southern Pediatric Seminar held at Saluda, N. C.

DR. H. E. ROLLINGS of Savannah has been called to active duty with the Air Force as a captain and is stationed at Hunter Air Force Base, Savannah.

DR. WILBUR M. SCOTT has returned to Milledgeville to practice medicine and he is associated in the operation of Scott Hospital, an institution established by his father.

DR. H. A. THORNTON, JR., a native of Decatur, announces that he will practice medicine in Greensboro.

DR. IRVIN H. TRINCHER, former resident in surgery at Emory University Hospital, Atlanta, announces his association with the Mary Black Clinic in Spartanburg, S. C.

DR. JOHN A. WARD announces the opening of his offices in the former W. D. Martin Clinic, Shellman, for the practice of medicine. He has been connected with the USN Hospital at Bethesda, Md.

THE BOOK SHELF

BOOKS RECEIVED

CLINICAL PEDIATRIC UROLOGY: By Meredith Campbell, M.S., M.D., F.A.C.S., Professor of Urology, New York University Postgraduate Medical School. With a Section on Nephritis and Allied Diseases in Infancy and Childhood; by Elvira Goettsch, A.B., M.D.; and John D. Lyttle, A.B., M.D., 1113 pages with 543 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price \$18.00.

CLINICAL AND RADIOLOGIC EVALUATION OF THE PELVIS IN OBSTETRICS: By Howard C. Moloy, M.D., M.Sc., Assistant Clinical Professor of Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University, and the Sloane Hospital for Women. 119 pages with 178 illustrations. Philadelphia and London: W. B. Saunders Company, 1951. Price \$2.50.

REVIEW OF PHYSIOLOGICAL CHEMISTRY: By Harold A. Harper, Ph.D., Lecturer in Surgery, University of California School of Medicine. Palo Alto, Calif. University Medical Publishers. 1951. Price \$3.50.

BOOKS REVIEWED

THE NEUROSES—Diagnosis and Management of Functional Disorders and Minor Psychoses: By Walter C. Alvarez, M.D., Professor of Medicine, Emeritus, Mayo Foundation, University of Minnesota; Emeritus Consultant in Medicine, the Mayo Clinic. 667 pages. Philadelphia and London: W. B. Saunders Company, 1951. Price \$10.00.

This new book on the diagnosis and management of functional disorders and minor psychoses by Dr. Alvarez, Professor of Medicine, Emeritus, of the Mayo Foundation, Rochester, Minn., is a refreshing addition to the literature of medicine. The author states his conviction in writing a book on the neuroses by a non-psychiatrist for a non-psychiatrist would be best served by a fellow non-psychiatrist.

The material contained in the book is largely drawn from a life-time experience in the practice of internal medicine at the Mayo Clinic. The book is well organized and very readable. Not only are the problems of diagnosis and treatment of the neuroses discussed but also the daily struggle of differentiating largely functional and largely organic disease, and most important of identifying chronic organic disease after it has become heavily encrusted with neuroses.

—EDGAR D. SHANKS, JR., M.D.

PIONEER DOCTOR: By Lewis J. Moorman, M.D. Cloth. \$3.75. Pp. 252, with illustrations. University of Oklahoma Press, Norman, 1951.

This autobiography by one of the South's most beloved and distinguished physicians was read and re-read by me some months ago while I occupied, through necessity, my bed at home. Having known Dr. Moorman personally for many years increased my interest in his most excellent book.

Born on a farm in Kentucky amid tobacco plants and a few horses, Dr. Moorman tells of his early life: his difficulties in college and in the University of Louisville Medical School, the beginning of a practice in rural Tennessee with few friends other than a loyal horse, the end of his Tennessee experience and more prospecting in the State of Alabama, particularly in and around Birmingham, for another practice; and finally his decision to go to Oklahoma to make his home and to "grow up" with the people of that State.

Dr. Moorman's book is well written and reflects throughout its contents the man himself: a most cultured gentleman who began his medical career in the "horse and buggy days" of American life, a gentleman and a physician who has come a great distance in his profession and whose attainments have been recognized by his colleagues throughout this and other countries. He is a past president of the Southern Medical Association and has held numerous offices in his home State, the most recent being the editorship of *The Journal of the Oklahoma State Medical Association*.

—EDGAR D. SHANKS, M.D.

PRACTICAL CLINICAL PSYCHIATRY—By Edward A. Strecker, Litt.D., LL.D., M.D., Professor of Psychiatry, School of Medicine, University of Pennsylvania; Franklin G. Ebaugh, M.D., Professor of Psychiatry, University of Colorado, School of Medicine and Director, Colorado Psychopathic Hospital; and Jack R. Ewalt, M.D., Professor of Neuro-Psychiatry and Administrator of Hospitals, University of Texas Medical Branch, Galveston. Section on "Psychopathologic Problems of Childhood" by Leo Kanner, M.D., Associate Professor of Psychiatry, Johns Hopkins University School of Medicine. 7th Edition; 35 Figures; 14 Tables; 506 Pages; June 13, 1951. Price \$7.00; The Blakiston Company, Philadelphia 5, New York 22, Toronto 2.

This well known text of clinical psychiatry enters the seventh edition with its 1951 publication and is testament in itself of the book's reception by physicians interested in the psychiatric aspects of medical practice. Considerable revision of material has occurred since publication of the sixth edition in 1947, particularly in regard to

classification and nomenclature, general or "support" therapy, and modifications in psychoanalytic therapy as dictated in part by the realistic demand for shortening the treatment time. Aside from the frankly psychotic individual, the realization that there are some 5,000,000 psychoneurotics in the United States who need treatment in addition to alcoholics, drug addicts, epileptics, mental defectives, juvenile and adult delinquents expresses the concern of this field of medicine with so few trained personnel to do the job.

—EDGAR D. SHANKS, JR., M.D.

THE WORLD MEDICAL ASSOCIATION

(Continued from Page 352)

We offer you the privilege of cooperating with us in the practical application of our medical ideals over the world. The cost is negligible, the benefits great.

A request to the office of your state association or to the undersigned will bring you immediate information and an application blank.

HAL M. DAVISON, M.D., Atlanta.

FIRST MEETING SCIENTIFIC WORK COMMITTEE

(Continued from Page 352)

Dr. R. Hugh Wood, Atlanta, was appointed Chairman of the Subcommittee in charge of Scientific Exhibits and Awards, with Dr. G. Lombard Kelly, as a member of this Committee. These men were requested to select a third member.

It was planned to arrange programs for the following sections, and to request these members to act as temporary chairman of each:

1. General Practice, Dr. Steve Kenyon, Dawson
2. Surgery, Dr. Luther H. Wolff, Columbus
3. Internal Medicine, Dr. Carter Smith, Atlanta
4. Urology, Dr. Reese C. Coleman, Jr., Atlanta
5. Pediatrics, Dr. John A. Simpson, Athens
6. Obstetrics and Gynecology, Dr. Richard Torpin, Augusta
7. Eye, Ear, Nose and Throat, Dr. Fred N. Aldrich, Macon
8. Orthopedics, Dr. Peter B. Wright, Augusta
9. Radiology, Dr. William W. Bryan, Atlanta
10. Psychiatry, Dr. J. R. Shannon Mays, Macon
11. Public Health, Dr. T. F. Sellers, Atlanta
12. Pathology, Dr. Everett L. Bishop, Atlanta

The Committee realizes that these involve some very drastic changes in our program, but we hope it will be successful in stimulating more interest in all members. A special effort is being made to fill the new Exhibit Hall of the Atlanta Biltmore with interesting Scientific and Technical Exhibits, and special features will be added. Your support and helpful suggestions are urgently needed, and requested.

PERSONALS

(Continued from Page 364)

DR. WILLIAM B. DILLARD, JR., has joined the staff of the Howell-Quillian Clinic in Cartersville.

DR. JOHN W. DANIEL, SR., 82-year-old Savannah physician, was honored recently as a pioneer in the study of diabetes and he was among the sixty doctors selected to first use insulin when it was released for use by the profession in 1922.

DR. T. EARL DUPREE announces that he will practice medicine at the Riverside Hospital in Bainbridge.

DR. ERNEST GOODALL EDWARDS, JR., announces the opening of his office for the practice of orthopedic surgery at 3½ East Gordon Street, Savannah.

DR. R. B. GILBERT, Greenville physician, is driving his 54th automobile. The physician owned the first car in Meriwether County, a red Maxwell, which he purchased in 1908. Dr. Gilbert operates the Gilbert Clinic in Greenville, but still makes calls over the county, both day and night.

DR. HARRIET E. GILLETTE of Atlanta has been made a diplomat of the Board of Physical Therapy and Rehabilitation of the American Medical Association. She is Medical Director of the Children's Rehabilitation Center at 1815 Ponce de Leon Ave.

DR. C. Stedman Glisson, Jr. announces the association of DR. ARTHUR A. SMITH at 1003 Medical Arts Building, Atlanta. Practice limited to Gynecology and Obstetrics.

DR. PAUL H. WILSON, a native of Waycross, has opened his offices in the Knox Building on Main Street in Thomson for the practice of medicine.

DR. LEWIS ROSS WHATLEY has joined the staff of the Howell-Quillian Clinic in Cartersville. Dr. Whatley graduated from Emory University School of Medicine, Atlanta, in 1948.

DR. LOYD C. YEARGIN, a native of Hartwell, announces the opening of his office for the practice of medicine in the clinic of the late Dr. George S. Kerr, Dalton. Dr. Yeargin graduated from the Medical College of Georgia, Augusta.

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EFFECT OF CORTISONE (CORTONE) AND PITUITARY ADRENO-CORTICOTROPHIC (ACTH) HORMONE ON PULMONARY DISEASES AND CONDITIONS

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TISSUE reactions to a proposed irritant are capable of producing pathological changes. Hormones (cortisone and pituitary adrenocorticotrophic) have little or no effect upon the irritant, but provide the susceptible tissue with a buffer against the irritant. During the acute phase of the disease, they suppress the unfavorable tissue reaction, and thus prevent anatomic changes and provide relief of symptomatology. In the light of our present knowledge, the following table may act as a guide to their use. It is obvious that early diagnosis with prompt use of the hormones insures the best results.

Certain diseases with pulmonary involvement are listed below and discussed in this paper.

- a. Bacteria—Pneumococcol septicemia can occur without fever or clinical evidence of such infection. Pneumonia may resolve rapidly with a sense of well-being.
- b. Antigens—Individuals known to be highly sensitive to specific antigens or drugs can be exposed to these antigens or drugs while under ACTH administration with no deleterious effects. Likewise, clinical syndromes associated with hypersensitivity phenomena can be blocked completely in patients already exposed.
- c. Chemicals—Patients sensitive to chemicals such as iodine, aminop-

<i>Beneficial Effects</i>	<i>Encouraging Effects</i>	<i>Transient Beneficial Effects</i>	<i>No Beneficial Effects Observed</i>
Bronchial Asthma	Pulmonary Granulomatosis	Lymphosarcoma	Pulmonary Tuberculosis
Silicosis		Hodgkin's Disease	Pneumonia
Berylliosis		Chronic Lymphatic Leukemia	
Löffler's Syndrome		Sarcoidosis	
		Pulmonary Tuberculosis (Where combined with streptomycin and para-aminosalicylic acid.)	

Fundamental and broad physiologic phenomena observed on adrenocortical stimulation are as follows:

1. ACTH appears to render cells immune to a wide variety of known toxic agents.

terin or mustard gas can be given these chemicals with no deleterious effects while under ACTH administration.

2. ACTH inhibits acute inflammatory re-

actions from almost any cause, including acute inflammatory diseases of the eye.

3. ACTH inhibits or diminishes pain from almost any cause.
4. Effects of adrenal cortical stimulation on central nervous physiology are:
 - a. Development of a sense of mental activity and well-being bordering on euphoria.
 - b. Development of psychoses from overdoses.

Tissue changes in the upper respiratory tract during pituitary adrenocorticotrophic hormone therapy have been closely observed.¹ Nasal polyps and nasopharyngeal lymphoid tissue have been removed and biopsied at varying intervals during treatment. Inspection of mouth, tongue and throat with trans-illumination and roentgenoscopic examination of sinuses have been completed. The results of these examinations show that nasal mucous membranes shrink, develop a pink color, and are covered with a thin layer of clear mucus. Polyps may be observed to become opaque, then pink, and to begin to shrink with complete disappearance in some cases. There is a correlation between these changes and the development of the initial eosinopenia. Nasopharyngeal lymphoid tissue becomes clearly distinct from surrounding structures by reason of its orange-pink color. Discharge surrounding these areas disappears. The same effect is produced by cortisone. Cortisone sprays may effect a definite regression of nasal polyps. Unfortunately, these tissues all revert to their original condition when the therapy is discontinued.

Patients who have diseases due to hypersensitive reactions such as asthma, intrinsic and/or extrinsic, may show dramatic relief of symptoms following the use of adrenocorticotrophic hormone (ACTH) or cortisone. In cases studied by Howard, et al.,² which had failed to respond to all of the usual antiasthmatic therapy, relief occurred a few hours after the initial dose. However, in one case, complete remission occurred only after eleven days.

It is suggested that 100 mg. of pituitary of adrenocorticotrophic hormone be given

for the first two days with reduction to 20 mg. per day for six to 14 days. The amount of each day's medication should be divided into four equal doses. Remissions do occur after varying intervals. Intercurrent respiratory infections may necessitate the combined use of epinephrine, aminophyllin suppositories, and other antiasthmatic drugs with the two hormones. When remissions necessitate, repetition of the hormone usually gives equally good response. Howard, et al.² also gave 200 mg. of cortisone the first day and 100 mg. per day thereafter for seven days. His study showed better results with the use of adrenocorticotrophic hormone than with the use of cortisone.

In asthmatic patients receiving pituitary adrenocorticotrophic hormone, the maximum fall in blood eosinophils occurs from the second to the seventh day of drug administration. There is correlation between the extent of eosinophil reduction and the degree of clinical improvement. However, toward the end of the course of treatment when the dose becomes lower than 30 mg. per day, the eosinophil count will rise although the asthma may still be improving or remain completely alleviated.

Administration of cortisone and pituitary adrenocorticotrophic hormone exerts beneficial action on the clinical manifestations of bronchial asthma. Pituitary adrenocorticotrophic hormone and cortisone may be profitably used as adjuvants in the treatment of asthma, provided they are not used in patients to whom the other physiologic effects of these hormones might prove deleterious.

Löffler's syndrome has been treated with dramatic results using adrenocorticotrophic hormone and cortisone, but few cases are reported in the literature to this date. The usual dose reported to give the best results is 35 mg. at two-hour intervals for four doses, followed by 25 mg. at six-hour intervals for 24 to 48 hours, with further decrease of dose over several days.

Metabolic studies of patients receiving pituitary adrenocorticotrophic hormone or cortisone acetate have demonstrated that body protoplasm is destroyed,³ while other studies have shown that either hormone inhibits growth in young animals and produces

atrophy of lymphoid tissues.⁴ With this theory in mind, Pearson and Eliel⁵ studied various types of tumors. To eight patients with chronic lymphatic leukemia, adrenocorticotrophic hormone and cortisone acetate was administered in a dosage of 100 to 200 mg. per day for periods of eighteen days to three months. All these patients showed appreciable shrinkage of enlarged lymph nodes, liver, and spleen during hormone administration. Regrowth of tumor masses occurred from two weeks to three months after discontinuation of the treatment. Indications are that refractoriness to administration of these hormones does not develop rapidly. Some improvement in the hematological picture was observed. Subjective improvement was noted during the first two weeks of treatment in all patients. This was characterized by a sense of well-being, improvement in appetite, and an improved capacity for mental and physical work. It is to be noted, however, that massive hemoptysis from small pulmonary abscesses may cause death during the course of the treatment.

The hormones may be used in the palliation of chronic lymphatic leukemia.³ Lymphosarcoma has been treated with the administration of adrenocorticotrophic hormone and/or cortisone which produces shrinkage of lymphoid tumor masses, including those located in the chest. Tumor masses localized in the neck have shown complete regression during administration of hormone for three months. Biopsy at this time showed no significant pathological alternation. But enlargement and biopsy at the end of the fourth month showed return of the same condition. Roentgen therapy then resulted in complete disappearance of adenopathy in one of Pearson and Eliel's cases. These two hormones may be used to treat some of the complications of this condition such as massive hydrothorax, massive obstruction to airways, and large blood vessels. Evidence of refractoriness to hormone administration has not been manifested during repeated courses of treatment over a period of one year. The reverse is true in the treatment of acute leukemia.

Hodgkin's disease has been treated by

the administration of pituitary adrenocorticotrophic hormone and/or cortisone acetate. During hormone administration slight shrinkage of enlarged lymph nodes and spleen has been noted along with decrease in elevated temperature and cessation of itching of the skin. Observations indicate that either of the two agents may produce slight, temporary improvement in patients with Hodgkin's disease, but lasting beneficial effects have not been obtained.

From the above studies it is evident that cortisone and adrenocorticotrophic hormone are very limited in their application even as palliative adjuncts, and can best be used to relieve symptomatology while other means of treatment are carried out.

These two hormones inhibit the formation of granulation tissue, depress macrophage activity, deplete lymphoid tissue, and reduce the function of the reticulo-endothelial system. Since the reverse is necessary to accomplish healing in pulmonary tuberculosis, it is postulated that the administration of adrenocorticotrophic hormone or cortisone is contraindicated. Therefore, the physician should assure himself that pulmonary tuberculosis does not exist in a patient who is being treated for other diseases such as rheumatoid arthritis. Spain and Molmut⁷ found that these hormones do not appear to have any action on granulation tissue already formed. They found that lesions in guinea pigs receiving cortisone appeared to be more extensive, more widely distributed, and less well localized.

D'Arcy, Hart, and Rees⁸ produced a chronic pulmonary tuberculosis infection in mice sufficiently stable to serve as a test infection. Intravenous injection of 0.0006 mg. dry weight of human-type tubercle bacilli produced an infection in mice that was relatively nonprogressive over six to twelve weeks and was characterized during this period by small, discrete, predominantly proliferative pulmonary lesions containing scanty tubercle bacilli. A daily dosage of 0.25-0.5 mg. of cortisone given subcutaneously for two to three weeks during the stable period of this chronic pulmonary infection greatly exacerbated the disease, with a resulting high mortality. The voluminous

lungs now contained large coalescing necrotic lesions with great numbers of tubercle bacilli. The more acute type of tuberculous infection in the mouse, produced by intravenous injection of 0.06 mg. of bacilli, was also aggravated by 0.5 mg. daily of cortisone, given from the first until the ninth day of infection. The chronic infection test proved highly satisfactory as a method for demonstrating increased susceptibility to tuberculosis due to cortisone. The acute infection test was more difficult to interpret. The effect of cortisone on murine tuberculosis is not likely to be due to depression of allergy or of collagen formation. Although human tuberculosis differs considerably from the murine form, and the present dosage of cortisone was relatively high, these observations should be kept in mind since tuberculosis in man may be similarly aggravated.

In rabbits and guinea pigs sensitized with tubercle bacilli (BCG), dermal reactivity to old tuberculin (OT) and to cytoplasmic particles from tubercle bacilli, as well as systemic shock produced by intraperitoneal injection of OT can be suppressed by treatment with cortisone. Four days after cessation of treatment the skin test again became positive.⁹

In human beings the use of ACTH⁹ produces preliminary rapid clearing of some lesions and a sense of well-being as well as disappearance of exhaustion and toxicity, but there is a spread of the infection co-existing.

In far advanced, hopeless cases which have laryngeal and bronchial involvement accompanied by swelling and pain, dramatic results are derived from inhalation of small amounts of these hormones.

Adrenocorticotrophic hormone and cortisone are not fibrolitic, but greatly aid in prevention of the formation of fibrous tissue. For this reason the two hormones have been used in the treatment of beryllium grandomatosis¹⁰ with good results. This disease is characterized by excessive fibrous tissue, cellular reaction in the interalveolar septal and occasionally by hyperglobulenemia. The vital capacity is increased, and there is improvement in roentgenograms. The question

of reversibility of this disease is questioned. Aggressiveness and emotional instability are often encountered as complications to treatment, even in small doses.

Silicosis requires long periods of observation to express accurate results of the use of adrenocorticotrophic hormone and cortisone, and experiments now being conducted are unreported in the literature. The object of these experiments is to stop the fibrolitic increase. It is known that present fibrosis cannot be reversed.

Finland has reported the results of the administration of ACTH in lobar pneumonia when no antibiotics were concurrently administered. In a few hours the temperature fell by crisis, and the patient became clinically and dramatically improved in 12 to 24 hours. This occurred in one case in spite of a positive blood culture for 35 hours after the beginning of ACTH administration. Dosage was tapered off for five days with almost complete clinical improvement. Symptoms of viral pneumonia recurred after omission of the hormone.

Effects other than the dominant therapeutic effect may occur such as: nutritional effect with increased appetite, strength, and weight; "psychic" effect with euphoria and increased mental energy, if nervous irritability or other changes in mood are not present; biological effect of increased hemoglobin and erythrocyte counts, and return to normal ratio of serum proteins. Emphasis is placed on avoidance of over-exercise and exhaustion during the patient's false sense of well-being. Other effects may be undesirable and are to be respected, not feared; therefore, controlled and adjusted dosage is of vital importance.

Effects that can be controlled without stopping the hormone therapy are:

1. *Edema*: In patients with unrestricted diet, pituitary adrenocorticotrophic hormone and cortisone acetate usually produce decided retention of fluids with resulting edema formation. Occasionally spontaneous diuresis occurs while hormone administration continues. Usually fluid retention continues until the hormone therapy is stopped, at which time diuresis occurs promptly. Pronounced fluid retention can be prevented by

KNOWN (OR PROBABLE) EFFECTS OF CORTONE

Metabolic

Increases gluconeogenesis.
Lowers renal threshold for glucose.
Opposes the action in insulin.
Increases absorption and storage of fats.
Increases protein catabolism, urinary nitrogen and urinary uric acid.
Increases deposition of hepatic glycogen.
May bring about retention of sodium.
Increases urinary excretion of chloride and potassium.
May increase calcium and phosphorus excretion.

Interendocrine

Effects on B.M.R. have been contradictory: May either depress thyroid activity (probably via diminished pituitary production of thyrotropic hormone) or increase sensitivity of tissues peripherally to thyroid hormones.
Increases insulin requirement. In individuals with normal pancreatic reserve, this requirement is adequately met, but in diabetes mellitus, additional insulin must be administered.
Relative hypoglycemia may occur following withdrawal of cortone.
Restore normal diuretic response to ingested water in Addison's disease.
May delay or inhibit menstruation, probably via depression of pituitary gonadotropic activity.

Neuromuscular

Restores capacity of muscle for work in adrenalectomized animals.
May increase muscle strength (in rheumatoid arthritis) or may cause muscle weakness (probably only in cases of hypopotassemia).
May cause increased activity in electroencephalogram (increase in frequency of alpha waves) or appearance of abnormal slow rhythms.
May restore electroencephalographic pattern to normal in Addison's disease.
May induce exaggerated sense of well-being and increased psychomotor activity.
May precipitate psychotic reaction (probably only in predisposed individuals).

Immunologic and Serologic

Tends to bring about restoration of normal A-G ratio in disease.
Diminishes antibody response to typhoid antigens in rabbits.
Diminishes or abolishes tuberculin reaction.
May prevent vascular lesions otherwise resulting from injection of desoxycorticosterone acetate (rats) or heterologous serum (rabbits).
Prevents or reduces tissue reaction to chemical irritants (guinea pigs).
May inhibit formation of histamine.

Cytologic

Produces lymphopenia (some species) and eosinopenia in peripheral blood.
May increase tissue eosinophils and metaplasia of fibroblasts into eosinophils.
Stimulates reticulocyte production or release.
May increase neutrophils in peripheral blood.
Inhibits fibroplasia.
Increases growth of macrophages in tissue culture.
Causes involution of lymphoid tissue and certain neoplastic tissue.

Enzymologic

Diminishes hyaluronidase activity.
Probably reduces blood glutathione.
Increases arginase in liver and kidney of mice.
Increases urinary excretion of uropepsin in patients with Addison's disease.

Reprinted from "Therapeutic Use of Cortone Acetate" (Page 39) by permission of Merck & Company, Inc., Rahway, N. J. Copyright 1950.

restriction of sodium chloride intake (low salt diet).⁵

2. *Alkalosis, Hypochloremia and Hypopotassemia:* These electrolyte changes occur frequently during administration of pituitary adrenocorticotrophic hormone or cortisone acetate, apparently the result of an intracellular potassium deficit. Symptoms and signs of potassium deficit may occur; i.e., apathy, lethargy, abdominal distention, cardiac irregularities, and muscular weakness or paralysis. The signs and symptoms of

potassium deficit can be alleviated, and the serum electrolyte changes corrected, by administration of potassium chloride without stopping the hormone.³

3. *Glycosuria and Hyperglycemia:* Diabetes occurs in a small percentage of patients receiving either of the agents. Glycosuria and hyperglycemia are usually moderate in degree and do not require treatment with insulin. The diabetes disappears when the hormone is stopped.

4. *Protein Metabolism:* In many pa-

tients, especially those receiving high dosage of cortone, continued administration of large doses usually produces a negative nitrogen balance. This may be overcome in certain instances by increasing the food (especially the protein) intake. Where reversed albumin globulin ratios are present, these tend to revert toward normal. Creatin and uric excretion are increased, and changes occur in the pattern of amino acid excretion.

5. *Atrophy of Tissue*: Metabolic balance studies of the effects of pituitary adrenocorticotrophic hormone or cortisone acetate in patients with lymphoid tumors have shown that not only is lymphoid tumor tissue destroyed but normal tissue as well. Prolonged administration of either hormone in sufficient quantity may produce severe wasting of muscle and presumably of other normal tissues. Weakness and debility may be associated with this loss of muscle mass aside from the electrolyte changes described above³.

Certain physiological effects require that the administration of the hormone be stopped such as:

1. *Hypertension*: Significant increases in blood pressure during administration of pituitary adrenocorticotrophic hormone and cortisone acetate may develop. Significant elevation of blood pressure during hormone administration requires careful observation or immediate cessation of therapy.

2. *Mental Disturbance*: A sense of well-being even in the presence of debilitating disease is a frequent early effect of the treatment with pituitary adrenocorticotrophic hormone or cortisone acetate. Sleeplessness is frequently noted during administration of these hormones. After several weeks of hormone administration a state of depression sometimes develops. Delusions have occurred after several weeks of hormone administration. Depression or delusions of psychotic manifestations probably demand immediate cessation of therapy. Severe reactions are more likely to occur in persons with backgrounds of nervous instability.

3. *Pyogenic Infections*: Lowered resistance to skin infections has been noted in patients. Prolonged administration of pituitary adrenocorticotrophic hormone or cor-

tisone acetate may impair the localization and resolution of pyogenic infections. Administration of either of the hormones should not be continued in the presence of infections which fail to respond rapidly to specific therapy. Bed sores occur and increase swiftly, and pulmonary infections may spread rapidly unless the hormone is stopped at once.

In some patients the hormone may produce evidences of excessive adrenal cortical effect such as rounding of the face, mild hirsutism, acne, striae of the skin, and amenorrhea in a few instances, especially in the young female. When these effects tend to develop, they can often be minimized or avoided altogether through adjustment of dosage and other measures. All these phenomena are reversible and disappear when administration of the hormone is discontinued.

Contraindications:

- Hypertension
- Diabetes mellitus
- Chronic nephritis
- Known psychotics and psychopathic personalities.
- Cushing's syndrome.
- Congestive heart failure.
- Hirsutism.
- Gastric or duodenal ulcer.

Because of their ability to suppress active disease manifestations, cortisone and adrenocorticotrophic hormone are especially valuable in the earlier stages of disease, before irreversible anatomic changes have occurred. Therefore, it is advisable to make early diagnosis and institute early treatment. The amount of these hormones must be varied in accordance with each individual case. In the average case, 100 mg. per day in four equal intramuscular doses is given for two days. The dosage should be reduced in accordance with the favorable responses and the occurrence of the side effects of the drug. Twenty mg. in four equal doses for four to eighteen days may be considered a maintenance dose. The smallest average daily amount required to maintain adequate control of the clinical manifestations is considered as the patient's maintenance dose. Readjustment of the dosage and "booster" doses may be required.

For chronic diseases requiring home treatment the oral⁶ use of cortisone acetate (tablet, saline solution, or syrup) has distinct advantages. It eliminates the discomfort of repeated intramuscular injections and makes the patient independent of others for his medicine. Oral cortisone gives quicker results, but does not last as long. Those patients who had previously received cortisone intramuscularly definitely preferred the oral route of administration. The less pronounced stimulation of mental activity and appetite is a practical advantage in the management of patients. The pattern of improvement with initial large suppressive doses given by mouth is similar to that observed in patients who had received equivalent amounts by intramuscular injection. No gastrointestinal symptoms have been observed.⁶

High incidence of unfavorable side effects when administration of cortisone and adrenocorticotrophic hormone is continued in large doses for extended periods, makes caution and selectivity a necessary measure. Serious trouble has been avoided until now by the strict regulations for its use. Now that the saline suspension of cortisone acetate has been placed on the market for sale, greater caution to prevent its indiscriminate use must be exercised. The knowledge that these hormones may be administered effectively by mouth should make physicians even more vigilant.

Prolonged administration of large doses of cortone in animals causes reduction in the size of the adrenal cortex. In humans, adrenal cortical suppression with muscular weakness and asthenia has been observed to occur for a brief period after treatment was abruptly withdrawn. This suggests that a transient period of adrenal cortical insufficiency may exist after the administration of cortone is discontinued.

Four types of evidence suggestive of adrenal depression by cortisone are:¹²

Postcortisone asthenia.

Depression of urinary 17-ketosteroids during and after administration of cortisone.

Diminished response to pituitary adrenocorticotrophic hormone.

Atrophy of adrenal cortices observed at necropsy.

SUMMARY

Effects of the two hormones on bronchial asthma, silicosis, berylliosis, Löffler's syndrome, pulmonary granulomatosis, lymphosarcoma, Hodgkin's disease, chronic lymphatic, leukemia, sarcoidosis, pulmonary tuberculosis and pneumonia are discussed.

The physiological phenomena, administration with pathological changes are described.

Known (or probable) effects of cortone are given in table form. Undesirable effects and contraindications are listed.

Great emphasis should be placed on the fact that the two hormones discussed in this paper should not be used as therapeutic agents in the treatment of infectious agents. There are certain indications, however, for the use of these hormones combined with antibiotics. When used in an infection with the specific antibiotic indicated, they may be a useful adjunct, when not contraindicated.

The now often quoted opinion that pituitary adrenocorticotrophic hormone (ACTH) and cortisone do not cure anything is probably correct.¹¹ Investigators have failed so far to explain how these substances work. Both agents affect not the cause of the disease, but the reaction of the tissue to the irritant or the cause. The dominant influence is on the pathologicophysiological changes or the disease itself, rather than on the pathologicoanatomic changes, or the causative factor of these conditions.

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STEVENS-JOHNSON SYNDROME OCCURRING IN IDENTICAL TWINS WITH APPARENT RESPONSE TO TERRAMYCIN AND AUREOMYCIN

J. H. PRITCHETT, JR., M.D., A. C. AUSTIN, M.D., Bremen

IT was in 1922 that Stevens and Johnson's¹ report on "Erythema Multiforme Bullosum with Involvement of the Mucous Membranes of the Eyes and Mouth" first appeared in the literature. Murphy² in 1944 noted that the "enanthem rather than the exanthen appears to be the most constant feature of the disease." Kove³ pointed out the dissimilarity between Stevens-Johnson syndrome and erythema multiforme exudativum which is characterized by a cutaneous eruption, mild constitutional symptoms, and possibly mild oral and ocular involvement.

The clinical course of Stevens-Johnson syndrome appears to be one of acute onset of fever and prostration associated with a cutaneous eruption, severe membranous stomatitis, and a purulent conjunctivitis. The oral lining is usually edematous and covered with numerous vesicles which soon rupture to be followed by the formation of a thick membranous exudate which soon sloughs off. The purulent conjunctivitis is usually severe. Panophthalmitis and partial to complete amaurosis occur not infrequently. A maculopapular or vesicular eruption of varying intensity may be present. The course is usually two to three weeks with relapse not uncommon. There may be a leukopenia or a leukocytosis. There is actually no characteristic laboratory finding. Bacterial studies have been entirely negative. Edgar and Synerton⁴ inoculated animals with vesicular fluid but recovered no transmitting agent. Kove's³ first reported case showed dysuria and pyuria, an initial leukocytosis with normal differential, negative blood and urine cultures, and a negative heterophile aggluti-

nation. The second case showed leukopenia, unilateral subauricular adenopathy, conjunctivitis, stomatitis, and temperature elevation to 106 (F.) degrees. There was no response to penicillin in either case.

Murray⁵ reported an apparent case of Stevens-Johnson Syndrome in which the rash was papulovesicular with the vesicles persisting for 19 days with no response to penicillin. Nelser⁶ also reported penicillin failure in the disease. Our cases followed much the same pattern in the first child with apparent shortening of the illness in the second who was treated initially with terramycin and aureomycin.

CASE REPORTS

Judy W., the first of the three year old identical twins, was seen by a physician because of fever and a subauricular mass on the left. In addition to these, a mild pharyngeal injection was said to be the only finding. On the second day of the illness she was hospitalized with a temperature of 103.4° F., a markedly enlarged and tender left subauricular node, general shotty cervical lymphadenopathy, catarrhal conjunctivitis, catarrhal stomatitis and pharyngitis, bilateral bronchopneumonia, and a rash consisting of several discrete, ovoid, erythematous macules with fawn colored centers distributed over the anterior thorax and upper anterior abdominal wall. She was given penicillin and streptomycin with prompt clearing of the pneumonitis, but a marked deterioration in the general condition. By the third day of the illness, the conjunctivitis had become mildly purulent with marked increase in conjunctival edema and injection. Vesicular eruption appeared on the buccal mucosa, soft palate, and posterior pharyngeal walls. There was apparently exquisite tenderness of the oral cavity, and all but the blandest foods were



Fig. 1. Shows crusting of lips, conjunctival injection and maculopapular rash in second of the twins.

refused. The cutaneous eruption by this time was generalized with involvement of the palms and soles. The rash was predominantly maculopapular with a few scattered vesicles appearing in some of the papules. Marked swings of the temperature occurred with the daily peak rising to 105° F. On the fourth day there was marked dysuria, and the vagina and periurethral mucosa were found to be diffusely hyperemic with a few scattered erythematous edged vesicles. By the fifth day the skin rash was fading, but the lips and oral cavity were covered by a grayish adherent membrane which left bleeding points when separated from the mucosa. The vaginal eruption was unchanged. The conjunctivitis had improved. Temperature rose to 105.4° F. At this time she was first seen by Dr. Austin who suggested the institution of terramycin 1.5 Gm. daily. On the sixth day only pigmentation remained of the cutaneous eruption. The buccal and vaginal eruptions were unchanged, but for the first time joint involvement made its appearance. This consisted of edema of the hands and feet with hyperemia of the overlying skin, tenderness on attempted use or on pressure or passive motion. There was fusiform swelling of all the fingers. At this time aureomycin 1.5 Gm. daily was added to the medication. On the seventh day there was general improvement. The oral membrane began to sep-

arate, the edema and joint involvement had regressed, and for the first time the temperature peak was less than 104° F. Steady improvement continued with a lytic fall of temperature, and by the eleventh day of the illness the only positive finding was desquamation of the fingertips and toes.

Laboratory findings: a leukocytosis of 18,800 with 75 per cent polymorphonuclear cells and 10 per cent stab cells, pyuria and cylindruria on the fourth and fifth days, negative blood cultures and negative agglutinations for typhoid, paratyphoid, typhus, brucellosis, and infectious mononucleosis were obtained. Convalescent agglutinations performed two weeks after recovery were also negative.

Joyce W., the remaining twin, was first seen on the ninth day after the onset of her sister's illness. At that time she had a fever of 101° F., mild catarrhal conjunctivitis, and mild, diffuse pharyngeal injection. She was given 1.5 Gm. each of terramycin and aureomycin daily. On the second day of her illness she was hospitalized due to the appearance of a generalized maculopapular eruption, vesicular stomatitis, pharyngitis, and catarrhal vaginitis with moderate edema of the involved mucous membranes. The oral lesions and those of the lips progressed to membrane formation, but the membrane was thinner and less adherent than in the other child, and by the fourth day of her illness it had separated leaving only mild hyperemia of the oral mucosa and dried crusting of the lips. The conjunctivitis did not become purulent, there was no joint involvement, and the temperature did not rise above 101° F. The patient was dismissed completely asymptomatic on the sixth day of her illness.

Laboratory findings: a leukopenia of 5,000 with a normal differential, a normal sedimentation rate on two occasions, normal total serum protein with normal fractionation, and only occasional leukocytes in catheterized urine specimens. Cultures and agglutinations as performed on the first child, including convalescent titres, were negative.

Summary

Two cases of Stevens-Johnson syndrome are reported. Penicillin and streptomycin cleared the complicating pneumonitis of the first case without altering the florid development of the collagen syndrome. Improvement, which could have been the natural course of events without the administration of terramycin and aureomycin, began with the oral administration of these antibiotics.

Oral administration of terramycin and aureomycin to the second of the twins did not prevent the development of the cutaneous eruption, conjunctivitis, or vesicular stomatitis, but did appear to definitely de-

crease the length and severity of the illness as compared to that of the first patient.

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THE TREATMENT OF GASTRIC ULCER

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BY custom, gastric and duodenal ulcerations are called peptic ulcer, and the terms have been used interchangeably for so long that many now regard the two lesions as synonymous. This is unfortunate, because they are quite dissimilar in nature, treatment and prognosis. Duodenal ulcer, which is a disease of the young, first appearing as a rule in the twenties or thirties, can be successfully managed medically in about 85 per cent of patients¹¹; surgery is indicated only in the 15 per cent of patients who de-

velop one of the complications of the disease—perforation, repeated hemorrhage, obstruction or intractable pain. Gastric ulcer, while subject to all the complications already mentioned, is also frequently indistinguishable from ulcerating carcinoma of the stomach. In 80 to 85 per cent of cases the treatment is surgical¹¹.

Perforation of a gastric ulcer is a surgical emergency and, as in perforation of any hollow viscus, calls for immediate laparotomy and closure of the perforation as soon as the patient can be prepared for surgery. It is wise to excise a portion of the perforation to rule out an ulcerating carcinoma of the stomach.

Hemorrhage from a gastric ulcer carries twice the mortality of hemorrhage from a duodenal ulcer¹², this is due to the fact that the majority of gastric ulcerations are located on the lesser curvature which may erode the left or right gastric artery, and hemorrhage is rarely followed by clotting. This is particularly true of patients over 45 or 50 years of age, and those patients who continue to bleed, or in whom repeated hemorrhage occurs even after hospitalization.

Pyloric obstruction secondary to a gastric ulcer is a serious complication, since such ulcers are prone to be malignant^{5, 11}. Unlike duodenal obstruction due to cicatricial duodenal ulcer, the high incidence of cancer in obstructing gastric ulcer militates against medical treatment with gastric suction in the expectation of subsidence of edema and relief of obstruction.

Gastric ulceration which causes intractable pain rarely yields to medical treatment, as this type of ulcer is usually deep with callous walls, and its base frequently consists of pan-



Fig. 1. Seven year history of epigastric burning pain relieved by alkalis. Exacerbations of pain with fever of 103°F.

Read before the Medical Association of Georgia in annual session, Augusta, April 19, 1951.

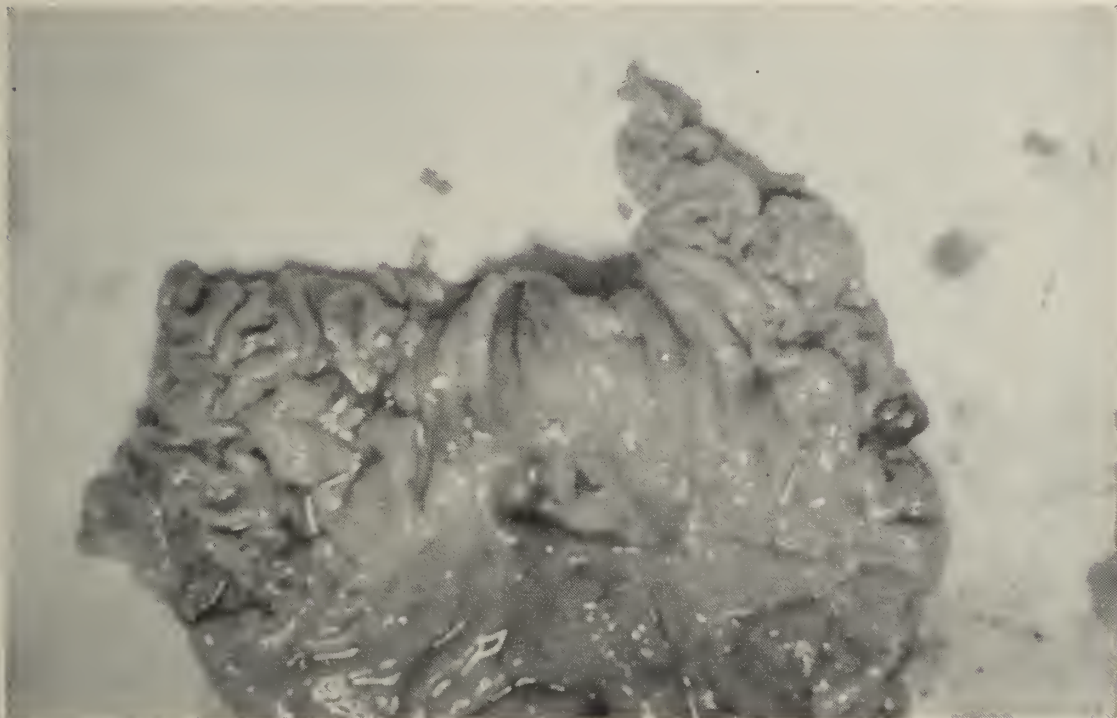


Fig. 2.—Gross specimen of patients in Figure 1. Note deep callous ulcer which had penetrated onto pancreas. This type of ulcer will not heal by medical management.



Fig. 3. Sixty year old white male with intermittent epigastric pain with vomiting and 25 pound weight loss in past 18 months. Stomach x-ray 12 months ago showed gastric ulcer; x-ray three months ago and ulcer healed. Symptoms continued



Fig. 4. Gross specimen from patient in Figure 3. Small indurated lesser curvature ulcer.

creas or liver into which the ulcer has eroded.

The greatest hazard in the therapy of gastric ulcer is the possibility of confusing benign ulceration with a small ulcerating carcinoma of the stomach. The physician who makes the diagnosis of peptic ulcer or duodenal ulcer on the basis of history and physical examination alone does his patient a grave injustice. Anglem³, in a study of 188 patients with carcinoma of the stomach, pointed out that the average time interval from appearance of the first symptom to the time of consulting a physician is nine months, whereas the average interval from onset of the symptoms to time of diagnosis is 17 months. This added delay of eight months was usually caused by the physician treating persistent indigestion without resort to gastric roentgenograms.

In 1909 Wilson and MacCarty¹⁴ published an article on "The Pathological Relationships of Gastric Ulcer and Gastric Carcinoma". This set off a controversy over the possibility of malignant degeneration in gastric ulcer which has been more distinguished for the heat of the argument that it generated

than for the light it has shed on the subject. This is indeed unfortunate, because it has obscured the more important fact that even with the aid of all modern diagnostic methods there are many patients with gastric ulcerations in whom it is impossible to be sure that ulcerating gastric cancer does not exist. The reports of Aaron¹, Anglem³, Lampert⁵ et al, Marshall and Welch⁶, Welch and Allen¹³, Judd and Priestley⁴, Walters⁸ and others⁹ show that the diagnostic error is 10 to 15 per cent in differentiating benign gastric ulceration from carcinoma of the stomach.

Several factors can be of help in the differential diagnosis, but all of them lead us into error at times.

The history may be helpful occasionally and at other times may be misleading. For example, Lampert and co-workers⁵ found that in patients with ulcer-cancer 28 per cent gave a history of typical "ulcer" distress starting five to forty years before operation. Walters, Gray and Priestley⁹ in a review of over 10,000 patients with gastric cancer found that 52 per cent of patients complained of dyspepsia and 28 per cent

had symptoms characteristic of duodenal ulcer. A history of any persistent indigestion of short duration in a patient over fifty should lead to a search for gastric cancer.

Age is another factor to be considered, the younger patients being less likely to harbor malignancy. It should be remembered, however, that the average age of gastric ulcer patients is above fifty years, as shown by the study of Lampert⁵ and others.

Location of the ulcer is of great importance. Ninety-six per cent of greater curvature or fundic ulcers, 40 to 65 per cent of prepyloric ulcers, and 10 per cent of lesser curvature ulcers are malignant regardless of size². Although only 10 per cent of lesser curvature ulcers are malignant, this is the site where error in differentiation from carcinoma is most frequently made.

The size of the ulcer is of some help. MacCarty¹¹ pointed out many years ago that any gastric ulcer greater than 2½ cm. in diameter (the size of a quarter) must be considered malignant until proven benign. This has been confirmed by Marshall and Welch⁶, Welch and Allen¹³, Walters, Gray and Priestley⁹ and others. In addition, Lampert and his colleagues⁵ found that the actual size of a large series of gastric ulcers was twice the size estimated by roentgenograms. Welch and Allen¹³ in 34 consecutive ulcer cancers found only one larger than 2½ cm. in diameter.

Gastric acidity levels offer little help. Normal acidity or hyperacidity is present in 65 per cent to 88 per cent of patients with ulcer cancer. Achlorhydria when present points to malignancy⁵.

Ancillary studies, such as gastroscopy and Papanicolaou smears of gastric washings, are helpful if they contribute positive evidence of malignancy, but they are not to be relied on if negative.

Response to medical therapy has been used as a guide to the benignancy or malignancy of gastric ulceration. Medical treatment should be confined to the small group of patients who are below forty years of age with a long history of dyspepsia, normal or above normal gastric acidity, and a gastric ulcer of less than 2½ cm. diameter when located on the lesser curvature. These patients should be hospitalized with bed rest and should be treated vigorously with antiacids, and antispasmodics, sedation, and frequent feedings of a bland diet. All other patients with gastric ulcer should be ex-

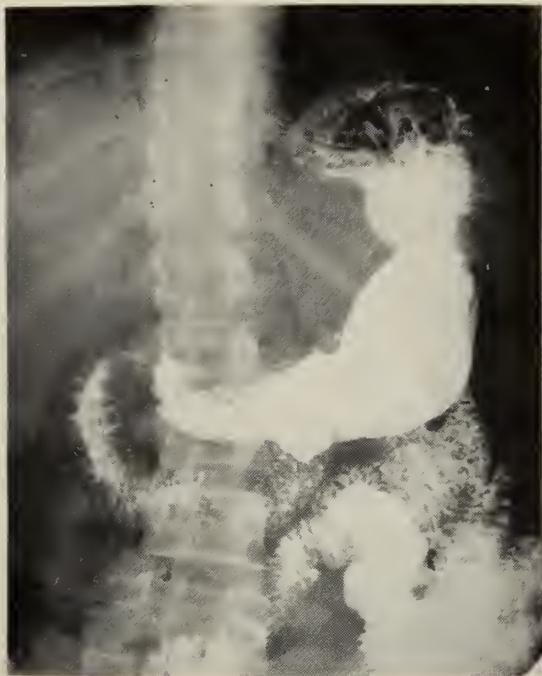


Fig. 5. Benign ulcer greater curvature in white female 57 years old with typical "ulcer distress". Ninety-six per cent of ulcerations in this location are malignant.



Fig. 6. Thirty-one year old white female with increasing epigastric distress. X-ray diagnosis of lesser curvature gastric ulcer three years ago; has been on medical therapy for three years. Exploration revealed extensive carcinoma of stomach with peritoneal metastases.

plored as soon as they can be properly prepared for surgery. Response to treatment should be evaluated by the patient's symptoms and by a gastric roentgenogram in two weeks. Complete healing or marked diminution in size of the ulcer has been taken as a sign of the benign character of the lesion, and usually justifies continued medical therapy with repeated gastric roentgenograms monthly until disappearance of the ulcer and for two to three months thereafter. There are several drawbacks to this program. Some patients feel better and are lost to follow-up observation. Wangenstein¹⁰, Walters⁸, Walters, Gray and Prisetley⁹, Welch and Allen¹³, Marshall and Welch⁶ and others have reported marked symptomatic improvement and even roentgenologic and gastroscopic disappearance of the ulcer on medical therapy only to find later that the lesion was malignant.

In short, there is a 10 to 15 per cent error in the differentiation of benign and malignant gastric ulceration without microscopic examination. As Anglem³ has stated, "A diagnostic method that depends for its success on observing the continued growth or persistence of a malignant tumor, in spite of treatment for weeks, has little to recommend it."

Delay in extirpation of a malignant ulcer, even for a short time, is extremely hazardous. Welch and Allen¹³ have shown that patients with a malignant gastric ulcer thought to be benign preoperatively but nevertheless operated in less than a month have a five-year survival rate of 40 per cent; similar patients who were treated medically for six months in the thought that the ulceration was benign but later operated had a five-year survival rate of zero.

Subtotal gastric resection is at present the treatment of choice for the great majority of gastric ulcers. Anglem³, Walters⁸, Judd and Priestley⁴ among others have pointed out that this operation, when done for gastric ulcer, is hardly ever complicated by recurrent ulceration, the "dumping syndrome", or marginal ulcer. It removes the pathology and prevents the possibility of obstruction, perforation, hemorrhage, intractable pain, and, most important of all, confusion with gastric carcinoma and its tragic results.

Summary

Gastric ulcer should not be compared with duodenal ulcer. Its character and com-

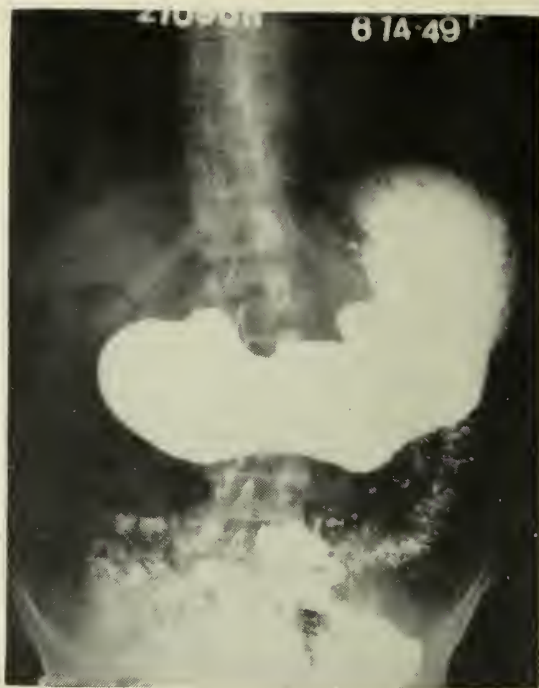


Fig. 7. Inadequate gastric resection for gastric ulcer 14 years ago. Now has nausea, vomiting one or two hours after meals. Note large pouch of antrum distal to stoma yet no marginal ulceration occurred. Relief by excision of antrum without disturbing anastomosis.

plications are dissimilar; its treatment in the great majority of patients should be subtotal gastric resection due to the large margin of diagnostic error in distinguishing it from carcinoma of the stomach.

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DEBUNKING THE "T AND A"

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THE time is past when the mere presence of tonsils and adenoids is a sufficient indication for their removal. Not long ago, about the time surgery began its great expansion, the easy accessibility of the tonsils, their apparent nonessentiality, and their somewhat evil appearance made them a natural to lead the parade. The ominous words "hypertrophied and cryptic" terrified many a patient and parent. In some places children had their tonsils and adenoids removed about as routinely as they were vaccinated and sent to school. In both children and adults there were a number of diseases wherein a tonsillectomy was considered either curative or a necessity¹. The patient who had a sentimental attachment to his tonsils became wary of even venturing into the throat surgeon's office.

Today the tonsillectomy and adenoidectomy continues as the most frequent operation performed, but for some time now the profession has cast a critical eye on the wholesale removal of these organs. Lately there have even been articles in lay publications on the subject, the most recent of which is from no less a medical authority than the *Readers Digest*—May 1951 issue².

It is true that the value of the T&A is being reappraised and its final worth has not yet been decided. We find many children who grow up keeping their tonsils and their health. After years of trial and error it is felt that the tonsils are not as momentous in the cause of other diseases as was formerly thought. The terms focus of infection, toxemia, and poisoning the system do not sound as dreadful as they did once, at least as far as the tonsils are concerned. Even chronic tonsillitis is now considered by many to be a vague diagnosis without much clinical or pathological basis.

On the other hand there is a belief that is becoming more widespread that the tonsils have a significant protective function and to remove them would be harmful. It is thought that they play a prominent role in the development of immunity and act as a barrier against infection³. While there may be some

truth in this, it is largely unproven. In fact, the idea can be traced back to the old Hahnemann homeopathic teachings⁴. It too can prove extreme since there are many patients who miss much time from work or school, endure heavy medical expense, and suffer needlessly because of this theory.

So the question is, what can actually be cured with tonsillectomy and what are the indications? We can be assured that after the tonsils are out the patient will at least have no more tonsillitis, and there is more or less general agreement that the most urgent indication is repeated attacks of the same. To be sure there are more indications for a tonsillectomy than just this but the farther we get from this basic idea the more likely we are to be disappointed in the result. As to the tonsils and diseases elsewhere it can be said that, in general, if the condition is associated to some degree with tonsillitis, there is a good chance that a tonsillectomy will help. If not, then there is a good chance it will not help. There are of course, unusual circumstances where there is a question as to whether the tonsils are having to do with the patient's troubles and their removal considered.

In children, the large obstructing adenoid is still important in the cause of mouth breathing and otitis media⁵. As most everyone knows suppurative otitis media is not the danger it once was. But there is another kind that remains as quite a problem and that is serous otitis media. This disease is now about the most common cause of hearing loss in childhood and is one of the most difficult problems of otology. The signs and symptoms are usually not striking as in the suppurative type. Frequently the only symptom is deafness. One of the more characteristic features of serous otitis media is that the eustachian tube becomes blocked with a tenacious mucous plug, and the middle ear fills with fluid. The resulting conduction deafness can be severe. In the small child whose only symptom is deafness, who has no pain or fever, and only obscure physical findings, the trouble can easily be overlooked, especially if it is unilateral.

However, these ears often become secon-

Read at the Emory University School of Medicine Postgraduate Medical Clinics, June 1, 1951.

darily infected and then the picture changes to that of suppurative otitis media. With the usual treatment the acute infection subsides, but the underlying pathology persists. This may happen over and over in a winter and commonly this is the case when a child has repeated abscessed ears at short intervals. The plug is removed at the same time the adenoids are taken out and the special technic used is that described by Dr. Lester Brown⁶.

Here is at least one condition in otolaryngology that has shown a relative increase, is seldom cured with penicillin and needs the particular skill of the ENT man both as to diagnosis and treatment.

In the relation between poliomyelitis and tonsillectomy, there is evidence that in the presence of polio, for a short period after the operation there is a somewhat greater chance of taking the disease and in a more serious form. In the polio season one must decide which is worse, leaving in the diseased tonsils or the potential threat of polio. In an epidemic the indications for tonsillectomy should indeed be urgent. In the

small child who has had a lot of tonsil and adenoid trouble, the one who needs a T&A most, the operation is no simple and safe procedure. Certainly the precautions taken to insure the safety of the child should not be minor. Serious complications and even mortalities occur more often than is ordinarily supposed. Yet in the properly selected case it may give a brilliant result^{7, 8}.

After considering this problem in all of its aspects, it is my reluctant conclusion that the day of chronic "remunerative" tonsillitis is about over.

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MEDICAL HISTORY OF GEORGIA

MEDICAL SCHOOLS WHICH EVENTUALLY BECAME EMORY

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Several factors contributed to the rapid growth of Atlanta since the granting of its charter in 1847 to its present-day metropolitan proportions. Nothing, however, played a more vital part than what was known as the "Atlanta spirit."

This was well-exemplified in 1854 by Dr. John G. Westmoreland, who had the audacity to organize a medical college in Atlanta, a town of 6,025 inhabitants, with a thinly-settled country surrounding it. (Five years later the population had grown to 12,000.)

At the same time, however, it must be remembered that the sole equipment required to conduct a medical institution of learning in those days was a lecture hall and, possibly, a dissecting room, although the latter was not always in use because there was no legally-regulated method for obtaining bodies for dissection. It has been claimed, though not admitted, that anatomical material was collected by surreptitious means.

As evidence of the difficulty to maintain such a school in a town so small, five professors of the original faculty of eight, lived outside of Atlanta and gave their addresses as New York City, Savannah, Newnan, LaGrange, and Auburn, Alabama. Membership in the faculty soon became limited to Atlanta doctors. However, several years later, Dr. Asa Griggs of West Point (after whom the distinguished Atlanta citizen, Asa G. Candler, was named) held a position on the teaching staff.

The institution known as the Atlanta Medical College did not begin actual operation until 1855. The first year's lectures were given in the new City Hall which occupied the present location of the State Capitol. This building presented modern features in architectural construction, chief of which were window sashes hung with weights to slide up and down. The enterprising, alert Dr. Westmoreland at once laid plans to erect a college building.

He was elected to the State Legislature for the sole purpose of securing \$15,000 toward the consummation of this object. In return, the medical school agreed to educate, free of charge, one student from every Congressional District of the State, a provision not now in operation. The building, located upon the present site of the colored division of Grady Memorial Hospital, was completed in time to house the second session of the college. The land was given by Col. L. P.

Grant, with the stipulation that if it ceased to be used for medical education purposes, it should revert to his estate. This philanthropist also donated the land for Grant Park.

Dr. John G. Westmoreland was a remarkable man. He was born in Monticello in 1816, and graduated from the Medical College of Georgia in Augusta in 1843. He was dean of the Atlanta Medical College and held the chair of *Materia Medica* and *Therapeutics* for forty years. It is related that he sold \$100,000 worth of Atlanta real estate at the beginning of the War Between the States, lending the entire amount to the Confederacy. The loan, of course, was never repaid. He did not believe that yellow fever was contagious and is reported to have slept with yellow fever patients in order to prove his contention.

In a booklet, "Atlanta As It Is," published in 1871 by Dr. John Stainback Wilson, Dr. Westmoreland is quoted as stating that in 1851 and 1852 typhoid fever prevailed in Atlanta as an epidemic. The number of cases, however, was not given. Dr. Westmoreland also claimed that no case of malaria ever originated in Atlanta, an impression which held ground for many years. Dr. Westmoreland, Sr., was the outstanding surgeon of this period, but had it not been for the vision, courage and energy of his brother, John, Atlanta medicine probably would have been held back for many years.

From the "History of the Atlanta Medical College," by Dr. Phinzy Calhoun, the source of many interesting facts, we learn that the first faculty meeting was held January 31, 1855, when Dr. J. W. Jones was requested to deliver the general introductory lecture on the first day of the following May. The lectures of this session ended on August 27, and examinations began on the 28th and continued for three days. Commencement exercises were held September 1st. In grading students, it was stated that four blackballs would reject, three blackballs would suspend for another term, while five whiteballs would elect. Of 78 students in the first class, 31 were granted the degree of doctor of medicine, while two were requested to repeat the course.

During these years, many men were practicing medicine who had only "read" it, but had never attended a medical college. Fortunately a medical practice act was passed about this time, requiring

of all doctors a license to practice, and permitting the granting of honorary degrees for those who had practiced legitimate medicine for as long as four years. In 1859, the Atlanta Medical College awarded the first honorary degree of this kind.

An old minute book records interesting events. At the first commencement, a procession of the board of trustees, faculty, and students marched through the streets to the City Hall. Oratory played a large part in the programs of the period; and so wonder, with the talent then on hand! At different times the speakers were Benjamin Harvey Hill, John B. Gordon, Alexander H. Stephens and Robert Toombs.

As the dean had no authority to spend money without a faculty resolution, the minutes show a carefully-worded resolution authorizing the dean to appropriate two dollars for cleaning out the well at the college. Another paragraph reads:

"Dr. Hillyer moved that the horse which was turned over to the dean in payment of a note given to the faculty for tuition be sold by him and the proceeds paid on the debt of Hunnicutt and Taylor against the college."

At a later meeting, the dean reported that the horse which he was ordered to sell had been sick but he thought he was getting better. Still later, he reported that the horse was well, but still unsold.

The financial difficulties of the young institution caused much concern, and were increased by the debts of the *Atlanta Medical & Surgical Journal* which the college was publishing. In 1857, the dean was authorized to negotiate a loan of \$5,000 to be secured by first mortgage upon the college building and for the purpose of settling some of the obligations of the institution. However, in 1859, a balance of \$700 was equally divided among the faculty members, probably the only pay they had received up to that time for their services.

Dr. Calhoun writes: "The year 1861 was an off-year for medical education at the Atlanta Medical College. The number of students was reduced, finances were bad, and collections worse. Little did the faculty know that this depression was only a warning of the terrible war which was to follow. A faculty meeting was held August 6, 1861. The secretary had started writing his minutes and had noted those present. He had begun a new sentence which was never finished. It seemed as if some great catastrophe had suddenly overwhelmed this meeting. One can now almost hear the roar of cannon and see the devastation and destruction which did not come then but two years later. War had come! It lasted four years, during which time all exercises of the school were suspended and the building converted into a hospital for the Confederate sick and wounded. A blank page follows the minutes of the last meeting, which appropriately serves as an unwritten memorial to the faculty and Atlanta Medical Col-

lege for the part they took in a cause which they thought was just."

T. H. Martin's "Atlanta and Its Builders" tells how the Atlanta Medical College building was saved in Sherman's destruction of the city in 1864. The credit for preserving the building belongs to Dr. N. D. D'Alvigny, a member of the faculty, who had been a soldier in France.

On the morning of the evacuation of the city by the Confederate forces, he was left behind and placed in charge of some wounded soldiers at the college building. When it was definitely announced that the city would be burned, Dr. D'Alvigny set his wits to work to save the building from going with the rest, if such a thing was possible. He distributed whiskey freely to his assistants, and instructed them how to act. When the squad of federal soldiers appeared to fire the structure the doctor told them that he had been in three armies and that this was the first time he had seen sick and wounded men burned without giving them a chance for removal. The officer denied that there were any such men in the building, that they had been carefully removed by military authority. Dr. D'Alvigny then threw open the doors, and exhibited men lying on pallets of straw and issuing distressing groans and appeals for attention. The officer, after witnessing this unexpected sight, gave the doctor until daylight to have the men removed. But when daylight came the danger was gone. Sherman's army had begun its march to the sea.

The school was reopened in 1865, and in 1866 two courses of instruction of five months each were offered—one in the summer, and the other in the winter. At this time, the city, appreciating the value of the institution, made a gift of \$5,000 to be used for refurbishing the building damaged by war. This donation, while sorely needed, was the cause of serious annoyance to the faculty for many months, and ultimately resulted in the resignation of Dr. Thomas S. Powell, who contended that since his influence was mainly responsible for the gift, it should be used for the improvement of his department of obstetrics. The matter was not seen in this light by the other members of the faculty; and in 1878, Dr. Powell and others established the second medical school which eventually was to become Emory, the Southern Medical College.

At this time the faculty of the Atlanta Medical College consisted of Drs. A. W. Griggs, A. W. Calhoun, Robert Battey of Rome, J. T. Johnson, G. W. Holmes, J. P. Logan, V. H. Taliaferro, W. A. Love, W. S. Armstrong, J. B. Baird, J. G. and W. F. Westmoreland. Later were added Drs. W. F. Westmoreland, Jr., W. S. Kendrick, V. O. Hardin, J. S. Todd, H. P. Cooper, W. S. Goldsmith, E. B. Block, Bernard Wolff, C. E. Boynton, C. W. Strickler, S. T. Barnett, F. P. Calhoun and J. E. Paullin. The names of the original faculty members of the Southern Medical College are not

BELOW

Top—Grady Memorial Hospital—1906

Middle—Atlanta Medical College—1915

Bottom—Atlanta School of Medicine—1910



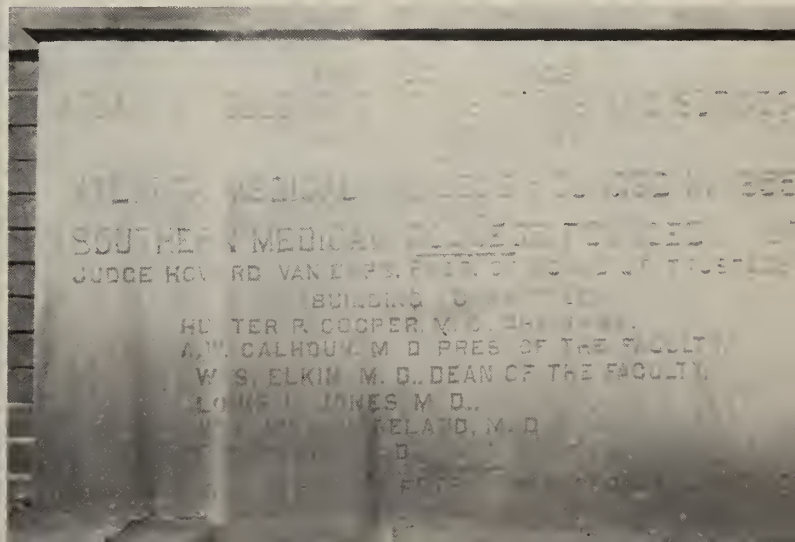
ATLANTA MEDICAL COLLEGE—1906



Historic Medical Sites



CORNERSTONE, COLLEGE OF PHYSICIANS AND SURGEONS



available, but during its twenty-year existence, the following were members, in addition to Dr. Powell: Drs. W. P. Nicolson, G. G. Roy, J. M. Gaston, W. S. Elkin, J. C. Olmstead, H. F. Harris, Dunbar Roy, F. W. McRae, James A. Gray and J. S. B. Holmes. The institution at first occupied a large brick building on what is today known as Edgewood avenue, near Pryor street, one of the several locations in Atlanta described as "Sherman's headquarters." Later the school erected a building adjoining the historic structure of the Atlanta Medical College, recently used as a home for the colored nurses of Grady Memorial Hospital.

There was always friendly rivalry between the two institutions, but with the increased cost of medical education it was recognized that there was room in Atlanta for only one first-rate medical college; so in 1898 the two united and formed the Atlanta College of Physicians and Surgeons, with Dr. W. S. Kendrick as dean. The new college opened its first year with an enrollment of 333, which was only fifteen short of the combined enrollments of the two old schools the previous year. Of this number, 214 were studying medicine; 88, dentistry; and 31, pharmacy. The Southern Medical College brought in the school of dentistry, and the Atlanta College introduced its school of pharmacy.

From Bullock's History of Emory University we read that the commencement of 1900, held at the Grand Opera House, was marked by the first use of caps and gowns. Dean Kendrick, in making his public report, stated that the enrollment was 277, and announced the decision of the faculty to require four courses of lectures for the degree, effective 1901.

The faculty of the new "P. and S." contained the names of most of the members of the faculties of the old schools, but dissatisfaction between different members reigned almost from the beginning and to such an extent, that only seven years later, in 1905, Dr. Kendrick resigned as dean, and Dr. W. S. Elkin took his place.

Immediately following this event, a movement was on foot to start another school of medicine. The time seemed ripe since several prominent members of the Atlanta profession, not connected with any school, wished to become teachers of medicine, and were ready with talents and funds to establish a new institution. These physicians, with several who left the faculty of the Atlanta College of Physicians and Surgeons, united to inaugurate the Atlanta School of Medicine. The original faculty members were: Drs. W. S. Kendrick, dean, E. G. Jones, J. L. Campbell, F. K. Bolland, W. B. Emery, R. B. Ridley, R. T. Dorsey, G. H. Noble, E. C. Davis, L. C. Fischer, C. D. Hurt, J. M. Crawford, E. C. Thrash, E. G. Balenger, S. R. Roberts and L. M. Gaines.

At first the new school shared quarters with the Atlanta Dental College in its new building at the corner of Edgewood Avenue and Ivy Street, but

the following year the Atlanta School of Medicine occupied its own building on Luckie Street, with a forty-bed hospital on the ground floor for colored patients. So far as is known, this was the first teaching hospital in Atlanta.

The new school was successful in both finances and attendance, but it soon realized that with the still-increasing cost of medical education, there was room for only one medical school in Atlanta. In the meantime the Atlanta "P. and S." continued to prosper and grow. In 1907 with the aid of a gift of \$25,000 from Andrew Carnegie, \$10,000 from Dr. A. W. Calhoun, \$5,000 from Dr. W. S. Elkin, and smaller amounts by other members of the faculty, the new building was completed on the site of the old structure which housed the Atlanta Medical College.

At this time Dean Elkin pointed out that the school then possessed five buildings devoted to teaching medicine, dentistry and pharmacy, and representing an investment of \$250,000. It was necessary, however, to float bonds for an additional \$50,000 to finance the remaining debts on the building. The main part of this structure then became the colored division of the Grady Memorial Hospital, affording the College of Physicians and Surgeons a teaching unit. While some instructors were now being paid small salaries for part time work, the first full time professor was Dr. H. F. Harris who came from Jefferson Medical College in 1901 to take over the newly-created chair of pathology and bacteriology.

The desire to secure the approval of the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association was an important factor in bringing together the Atlanta College of Physicians and Surgeons and the Atlanta School of Medicine. In 1912 the former institution adopted the 14-unit requirement for approval, and was informed that, if numerous improvements were made, the college might be put on Class A rating in another year, but that if the two schools would combine, the single institution could be placed in Class A at once.

Negotiations were begun, and articles of agreement soon completed the uniting of the two faculties, and thus producing an organization strong in its teaching staff, and better able to meet the increasing demands put upon medical colleges. On September 20, 1913, the consolidation was effected under the original name of the Atlanta Medical College, the last of the schools which had separated from the parent institution, and the way paved for it to become the medical school of Emory University.

Dr. W. S. Elkin was made dean; and under his wise, diplomatic, unselfish leadership, an honest effort was made to approximate the admission requirements of Class A medical colleges without losing too much patronage and income. The admission requirement of one college year of biology, chemistry, physics and a modern language

was announced as effective in 1914, but was not enforced until 1915. As Bullock remarks, "Even this gradual lifting of the entrance standards produced definite decreases in freshmen registration, and it became increasingly clear that without considerable endowment the Atlanta Medical College could not survive." The day of the proprietary medical school was over.

In 1915, Emory College, the historic Methodist institution at Oxford, was moved to Atlanta, and became Emory University. This was indeed a timely event: the medical school needed Emory, and it could be said with equal emphasis, that Emory needed the medical school in order to become a completed university. Plans for a union of the two institutions were studied by various committees, but the ultimate success of the pro-

posal was due mainly to the efforts of Dean Elkin and the generous Atlanta citizen, Asa G. Candler. The official date of the consummation of the merger was June 28, Dr. Elkin being retained as dean. Thus began the development of the modern medical school of today, quite different from the modest affair of John G. Westmoreland sixty years before. But how he would have loved to have taken an active part in it!

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WASHINGTON NEWS

ENLIST SUPPORT IN BEHALF OF IVES AMENDMENT. With the Senate finance committee deciding suddenly to consider the Ives amendment to the tax bill (H.R. 4473), the AMA wired executive secretaries of all state societies last month to initiate whatever support they could in behalf of the amendment, which would eliminate discrimination against the self-employed in providing retirement benefits with tax deferred income.

Under existing federal tax laws, physicians who practice as individual proprietors or partners face certain tax inequities with respect to pensions. Therefore, favorable action on the Ives amendment is important to all physicians.

AMA REPRESENTATIVES MEET WITH U.M.T. COMMISSIONERS—Representatives of the AMA's *Council on National Emergency Medical Service* met with the *National Security Training Commission* on August 17 to give the commission the Association's views on the medical aspects of the Universal Military Training program. Under the draft law extension, Congress instructed the Commission to prepare a review covering both military and non-military phases of the Universal Military Training program. Included are housing, recreation and health. Not until Congress has received this report can the program be started.

TRUMAN VETOES BENEFIT BILL, CRITICIZES VA NON-SERVICE CARE SYSTEM—President Truman took advantage of a veto message to re-emphasize his opposition to the system under

which two-thirds of Veterans Administration hospital cases are *non-service* connected. The vetoed bill would apply only to disabled veterans whose disability was *not* service connected. It would increase benefits for such veterans who require the attendance of another person (nurse included) from \$60-\$72 per month to \$120. The President pointed out that the bill would cost \$16,700,000 the first year, increasing as the veteran population grows older to a peak of \$400,000,000 annually.

INDIANA SUES TO FORCE EWING TO RESUME U. S. WELFARE PAYMENTS. A legal showdown is due shortly in the dispute between the State of Indiana and Federal Security Administrator Oscar Ewing over U. S. welfare payments to that state. Two weeks ago Mr. Ewing cut off Federal payments to Indiana for old age assistance, aid to dependent children and assistance to the blind and other handicapped. He pointed out that a new Indiana law opening welfare rolls to "*public inspection*" was in violation of federal laws imposing secrecy on the lists, and that therefore he was required to stop the payments. Now Indiana's Attorney General J. Emmett McManamon has filed suit in U. S. District Court in the District of Columbia, stating that an emergency exists in the state and calling on Mr. Ewing to resume the payments. Mr. McManamon claimed that the Indiana statute was not in violation of the federal confidential requirement because it restricts inspection of recipients' names to "purposes directly connected with the administration of assistance." Prompt action on the suit is expected.

THE JOURNAL

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DAVID HENRY POER, M.D., Editor

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SEPTEMBER, 1951

JAMES EDGAR PAULLIN, M.D.

1881-1951

In a small town located on the Chattahoochee river separating the southern parts and Georgia and Alabama a future leader in American medicine was born without fanfare in November of 1881. He was one of four children born to hard working and thrifty parents who were classed as planters of modest means, and who required that all the children contribute their share of work to provide a happy and properly rounded home-life. It was the mother more than anyone else who provided the great stimulation to Edgar to go out into the world and make a name for himself.

James Edgar Paullin's early and late education has been described elsewhere including time spent at Mercer University in Macon, and at the Johns Hopkins University School of Medicine in Baltimore. Here he came under the influence of that great medical teacher, Dr. William Osler and other members of that exception staff, who provided the stimulation and careful training necessary to produce the unusual physician. He never visited clinics in Europe, but learned the meticulous and scientific methods of teaching from members of the Johns Hopkins faculty and from a close German friend, in whose home he lived during his Baltimore stay, and also the stern manner of the successful pedagogue. Later more time was spent in studying and teaching pathology in Providence and Atlanta which he always considered to be the absolutely necessary foundation to a scientific knowledge of medicine. Upon such exact information could then be built the art of diagnosis and treatment of diseases.

Early in his medical life he became particularly interested in the study of diabetes and his researches in this field later brought him renown and the first touch of fame. Later his studies of diseases of the heart and circulatory system, especially the ravages of syphilis in the colored race because of the vast amount of pathologic material of this type available at the Grady Memorial Hospital in Atlanta, increased his prominence in the field of internal medicine.

Even though Dr. Paullin carried on these and many other special studies in the field of medicine, it will probably be as a great medical teacher that he will be remembered best of all. He loved

it, he studied it, he worked hard at it even without salary, and money was not too plentiful in the early days of his career. He was a hard and stern taskmaster, but inspired and required his students to learn the basic fundamentals of medicine.

Later he demonstrated his ability in another field of medicine that to many of us seemed not all-together in character for one so intense in following the scientific methods of practice and teaching. As a leader in many medical organizations including the necessary political activities, he showed keen perception of his responsibilities by helping to improve the entire structure of organized medicine, including service as an official of the American Medical Association. No doubt he saw the creeping inroads of socialized medicine slowly entwining itself around the throat of free unrestricted practice and placed a bold shoulder in opposition to such destructive changes.

Though he had reached an age that most men considered adequate to stay quietly at home and let others carry on medical leadership during World War II, he actually became even more active than ever before. Covering his office practice as best he could, he spent half the time in Washington or touring military hospitals in this country and abroad, lending his abilities as a medical teacher and organizer wherever needed. Having had a serious chest ailment in his early days, and never exactly robust in physique, he spent his energies freely, keeping pace with men much younger and much stronger. These activities no doubt were to take their toll, and bring about destructive changes that ultimately helped cause his death.

Despite all of his high professional accomplishments both in scientific and educational fields and in medical organizations, it was in his home that he was at his best. As a devoted husband and father, he derived his greatest joys with his wife and daughter, but his close interests in all the activities of his grandchildren knew no bounds. One of his last concerns on the day of his death was the replacement of a front tooth lost in an accident by his grandson who was part of his very soul. Never the easy back-slapping type, he was available to his friends and spent much of his time giving advice and counsel particularly to young doctors anxious to improve their status in the profession.

Customarily we measure the stature of an outstanding person in terms of loss to the family, community, and nation. Dr. Paullin would prefer to be remembered by his accomplishments, which were wide and varied. His students are better doctors, his societies and organizations are better prepared to carry on their important functions, his city, State and country are better places to live in, and his friends are richer having had the warm association of such an inspiring character. He called for serenity in others but was dynamic even in the moment of death.

THE SERVICE OF REMEMBRANCE FOR DR. JAMES EDGAR PAULLIN

at Spring Hill, Atlanta, Georgia
August 15, 1951

ROBERT W. BURNS, D.D.

*"Grace to you and peace from God,
our Father, and the Lord Jesus Christ."*

Others have already told in ample detail the story of the major accomplishments of Dr. James Edgar Paullin. The news stories and editorials in the daily papers have reviewed the major triumphs of his long and useful career. All of this is known to each of us today and it would be superfluous to attempt again to describe the many ways in which he succeeded in his chosen profession.

Your attention is directed today to an area of his life which has been largely ignored by the published statements. For twenty-one years it was my privilege to know him personally as well as professionally. He was the physician of our family and all of us had received his tender and thorough services.

On last Monday afternoon when he was stricken with what he knew was a fatal illness, Dr. Paullin reported to those around him the symptoms which he recognized of the approaching end. During those anxious hours his deeply religious faith was expressed in these words, "My house is in order and I am ready to go."

Those of us who came to know him intimately were impressed with his gentle wisdom. He gave away hundreds of copies of Sir William Osler's Essay, "A Way of Life," which expressed his own philosophy. During recent months he had cards printed

which he handed to many of his patients, on which was printed this prayer:

*"God, give me the serenity
To accept the things I cannot change,
The courage to change the things I can,
And the wisdom to know the difference."*



JAMES EDGAR PAULLIN
1881-1951

The world knew him as a famous physician. We remember him today as a lovable person who shared with us his own victorious faith in the living God and in His Son, our Lord and Saviour, Jesus Christ.

There is a beautiful appropriateness in one of the stories told by Christ which we apply directly to Dr. Paullin's more than two score years of service among us:

"Then shall the King say unto them on his right hand, Come, ye blessed of my Father, inherit the Kingdom prepared for you from the foundation of the world:

For I was an hungered, and ye gave me meat: I was thirsty, and ye gave me drink: I was a stranger, and ye took me in;

Naked, and ye clothed me: I was sick, and ye visited me; I was in prison, and we came unto me.

Then shall the righteous answer him, saying, Lord, when saw we thee an hungered, and fed thee? or thirsty, and gave thee drink?

When saw we thee a stranger, and took thee in? or naked, and clothed thee?

Or when saw we thee sick, or in prison, and came unto thee?

And the King shall answer and say unto them . . . Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me." (Matthew 25:34-40).

(Continued on next page)



JAMES EDGAR PAULLIN

(Continued from preceding page)

From the apocryphal book of Ecclesiasticus, let us use these words as a tribute to him:

Let us now praise famous men,
And our fathers that have taught us.
The Lord manifested in them great glory,
Even his mighty power from the beginning.
Such as did bear rule in their power,
Giving counsel by their understanding,
Leaders of the people by their counsels,
And by their understanding men of learnings for the people;
Wise were their works in their instruction."
(Ecclesiasticus 44:1-4)

"Honour a physician according to thy need of him with the honours due unto him:
For verily the Lord hath created him.
For from the most High cometh healing;
The skill of the physician shall lift up his head;
And in the sight of great men he shall be admired.
The Lord created medicines out of the earth;
And He gave men skill,
That they might be glorified in his marvelous works.
With them doth He heal a man,
And taketh away his pain.
And his works shall not be brought to an end;
And from him is peace upon the face of the earth."
(Ecclesiasticus 38:1-8)

(The funeral was conducted by the Reverend Robert W. Burns, D.D., pastor of the Peachtree Christian Church, and Rev. Allen Gardner, assistant pastor, First Presbyterian Church.)

THE MILLEDGEVILLE "ASYLUM"

DEFINITION

ASYLUM: 1. An institution for the maintenance and care of insane, orphans, etc.; 2. An inviolate refuge for criminals and debtors, etc.

During recent months an increasing amount of publicity, some of its uncomplimentary, has centered about conditions at the State Mental Hospital in Milledgeville. This situation, no doubt, has caused *The Atlanta Journal* to publish a series of articles about the institution written by Jack Spalding, whose penetrating observations have brought forth a valuable word picture for the study by all Georgia citizens.

As doctors and as citizens, all of us have known something of the unsavory conditions that existed at Milledgeville but none of us were prepared for the findings brought to light by the recent tragic mishandling of an inmate, and also by some of the revelations in the Spalding report. These conditions have again caused our sister states to point the finger of scorn and avarice at our State under whose supervision the institution is operated, staffed and managed. Now the challenge has been put up to us and the doctors in Georgia are strongly behind the Administration in its efforts to bring the care of its unfortunate mental cripples to an acceptable level.

Basically our program in Georgia has followed the mid-Victorian conception of handling "crazy people" by legal procedures rather than by the use of more modern methods based on advances in psychiatry. The handling of an insane person by the sheriff as a criminal behind the bars of the jail has been outmoded and should be stricken from our law books.

Present day conception of mental disease considers it along with physical ailments that require proper diagnosis and treatment after consideration of type, severity and duration. Some conditions can best be treated in the sympathetic atmosphere of the home, with occasional visits to the doctors office. These include many of the so-called "senile dementias" who are now conveniently dumped on the State for simple custodial care even by well-to-do families and heartless children. Others can be admitted at intervals to institutions properly equipped and staffed to carry out "shock" and other forms of therapy under the direction of psychiatrists and physicians. Separate departments in general hospitals can easily handle many patients in this category, but unfortunately the responsible authorities have not included such plans in the construction of the new hospitals being built over the State.

Concretely the things that can be done by the citizens of this State to help improve our care and treatment of the mental sick included the following:

1. A change in the basic law which handles the insane as a criminal and may actually make the mental condition worse at times. When the ability of the individual to reason and make decisions is involved, use should be made of medical commissions with psychiatrists acting as consultants.

2. Permit voluntary application for treatment in the State Mental Hospital. This would avoid the stigma of a court having to issue a warrant and the sheriff being forced to take over custody of a mentally sick patient.

3. Include psychiatry departments in all of the general hospitals that are being constructed with State funds, and give the ordinary of each county the necessary authority to have a diagnosis made and treatment recommended at this point. Some treatments could be carried out at this level.

4. Carry out the suggested plan of having a screening center near, but not a part of the Mental Hospital in Milledgeville, and require all new patients to be studied there before admission to the institution. Staffed by experts in psychiatry such a unit would assure the unfortunate patient of a correct diagnosis and an accepted regimen of treatment to insure a cure or improvement. Proper screening would prevent admission of all patients with organic conditions, chronic alcoholics, narcotic addicts, and old people who have a simple reversion to a child level of mental activity. This alone

would save the State enough money to pay for its maintenance.

The psychiatry departments in the general hospitals in the more heavily populated counties with a staff of qualified psychiatrists could be subsidized by the State to act as screening centers, when the legal aspects of the case require action by an official agency. This would also save the State money, and permit the individual to avoid the stigma of having been admitted to a mental institution unless actually suffering from a serious mental disease.

5. Appointment of a joint commission by the Governor, composed of representatives from the Legislature, the Governor's staff, and the Medical Association of Georgia to study the problem from all aspects and make recommendations to the Legislature concerning necessary changes in our laws. Such a commission could call in representatives from such groups as the psychiatrists, the county officials (ordinaries and sheriffs), the medical colleges, the Georgia Medical Association, the Georgia Hospital Association, the Georgia Nurses Association, and the State Department of Public Health for advice and suggestions.

This is a positive program to help correct a distressing situation in our State, and it will receive the forceful support of the members of the Medical Association of Georgia.

Let us bring our consideration of these mental unfortunates from the dark days of an "asylum" up to the humanitarian advantages of a mental hospital.

RELATION OF CANCER CONTROL AGENCIES IN GEORGIA

The Cancer Commission of the Medical Association of Georgia, The Cancer Control Service of the State of Georgia Department of Public Health, and the Georgia Division of the American Cancer Society are all concerned in cancer control in the state of Georgia. While all three of these are closely related and cooperate with each other at all times, their functions and services are not identical. Since there has been some confusion in the minds of the medical profession as to the aims and functions of these three groups, the Cancer Commission of the Medical Association of Georgia thought it would be advisable to briefly summarize the functions and relationships of these groups.

The Cancer Committee of the Medical Association of Georgia was originally set up by a resolution passed at the Annual Session about 1934 or 1935. This committee was given space in *The Journal* and was charged with the promotion and encouragement of cancer education and the improvement of facilities for the diagnosis, treatment, and care of cancer patients in the State of Georgia. Very soon after this committee was established, the Georgia Cancer Control Law was enacted, and in

this law the Cancer Committee of the Medical Association of Georgia was set up as the cancer commission to be the advisory committee to the Cancer Control Service of the State of Georgia Department of Public Health. Although this committee has no definite powers other than that of advising how the cancer control law should be carried out, they have cooperated continuously and very actively with the Department of Public Health and their advice has usually been accepted and issued in the form of regulations by the Cancer Control Service. It was largely through the efforts of this committee that the state aid system of clinics in Georgia was established and it has also been through their efforts that this system has been improved and financial support for the increasing demands of this system has been obtained. Under the resolution setting up this committee, the President of the Medical Association of Georgia was given complete authority to appoint all members annually. However, most of the personnel have been maintained on this committee for many years and as a general rule, only those physicians vitally concerned with the problems of cancer control have been reappointed to this committee.

The Georgia Division of the American Cancer Society, as its name implies, is a component part of the national organization. This organization has as its purposes the raising and spending of funds to carry out cancer research and education, and to render service to cancer patients. The greatest part of the work of the Georgia Division is carried on by a large number of volunteer workers who are organized in city and county units. These volunteer workers do most of the work and fund raising and most of the work of lay education. The value of this work is beyond any estimation. Sixty per cent of the funds raised by the Georgia Division are used in the State of Georgia and 40 per cent goes into national treasury and of these 25 per cent are earmarked for research grants to institutions, and individuals. All funds in the Georgia treasury are allocated by the Board of Directors where it is most needed and can accomplish the most good for cancer control work in Georgia. The American Cancer Society is also a medical and scientific organization and cancer programs for the medical profession are sponsored and arranged by this organization. Many such programs have been put on throughout the entire state.

While the medical members of the Board of Directors of the Georgia Division are not identical with the members of the Cancer Commission of the Medical Association of Georgia, the great majority of the members of the Cancer Commission are also directors of the Georgia Division.

The Cancer Control Service of the Department of Public Health operates the state aid clinic system whereby cancer clinics associated

with recognized general hospitals which meet the minimum standards of the American College of Surgeons may receive aid for indigent patients treated in these clinics. This aid is cost-price for x-ray treatment and a per diem payment for hospitalization of approved cancer patients. The staffs of the clinics do not receive any payment for their services to state aid patients.

As can be seen, the three agencies concerned with cancer control are very closely related and have an interlocking, though not identical medical governing body. In the past the cooperation of these agencies has been excellent and the results of their good work is very apparent to anyone who takes the trouble to look into the matter. The participation of a larger number of the medical profession in the American Cancer Society is a very desirable thing and every effort is being made to encourage more doctors to attend the annual meetings and clinical conferences of this organization.

(Florida, having experienced difficulty in coordinating the work of the various cancer groups has recently set up the Florida Cancer Council with approval of the State Medical Association. This statewide cancer control commission consists of two members representing the Florida Medical Association, two from the State Division of the American Cancer Society, two from the State Board of Health, and one from the American College of Surgeons. The cancer control program is under the direction of this council. Such an organization in Georgia might be worthy of consideration.—Ed.)

OUR CANCER ORGANIZATIONS

Beginning with this issue there will be published each month an unsigned article submitted by the Cancer Commission of the Medical Association of Georgia dealing with some phase of cancer work in Georgia. Very properly the first article concerning itself with an explanation of the organization, composition and function of the several separate cancer groups operating in the State. Perhaps little confusion has occurred in Georgia due to the fact that the medical representatives in all groups are usually the same persons. However it requires one to stop and think on each occasion as to whether Elliott Scarborough or Enoch Callaway is speaking for the Medical Association of Georgia or the Georgia Cancer Society, or the Cancer Committee of the Georgia Chapter of the American College of Surgeons.

Perhaps the entire picture can be made clear by considering that one group is made up of surgeons alone (Cancer Committee, Georgia Chapter of the American College of Surgeons), the next is made up of doctors of all types (Cancer Commission of the Medical Association of Georgia), and the third has participation by laymen and doctors who have more than average interest in cancer control (Executive Committee

of the Georgia Division of the American Cancer Society). All persons contributing funds for the work of the American Cancer Society automatically become members of the Georgia Division, and are invited to the annual meetings, such as the one held at the Atlanta Biltmore on September 14-15. Also it should be noted that the Department of Public Health has a Division on Cancer Control which directs the distribution of all aid given to worthy patients in Cancer Clinics throughout the State. This is headed by Dr. Wm. J. Murphy with offices in Atlanta.

Similar confusion exists in other states and Florida has recently attempted to correct the situation by formation of a Cancer Council under the auspices of the Florida Medical Association. Probably the fact that the same physicians so frequently represent all three groups in Georgia, thereby controlling the activities and policies of each, prevents any duplication of efforts. Whether this is a wholesome situation or not depends on one's viewpoints and interests, but broader participation in cancer work by more physicians and more laymen would seem to be both desirable and profitable to the program.

Attention is called to the annual meeting of the Georgia Division of the American Cancer Society with both scientific programs and also separate discussions concerned with other problems of the State and national organizations. One of the most distinguished oncologists of the country, Dr. Ralph L. Clark of Houston, Director of the M. D. Anderson Hospital for Cancer Research, will participate in both programs. Again on October 18 in Augusta at the time of the annual meeting of the Georgia Chapter of the American College of Surgeons, its cancer committee will sponsor a program under the direction of Dr. Hoke Wammock, Director of the Cancer Clinic of the University Hospital, Augusta. Participating in this program will be Dr. Alton Ochsner, New Orleans, President-Elect of the American College of Surgeons, Dr. Ralph Caulk, radiologist at the Garfield Hospital in Washington, and Dr. Julian Johnson, thoracic surgeon, Hospital of the University of Pennsylvania in Philadelphia. Last on the list, but first in 1952, will be the program sponsored by the Cancer Commission during the Annual Session of the Medical Association of Georgia in Atlanta, May 11-14.

All doctors are always invited to all the Sessions. Plan to attend one or more each year.

Everybody clear on cancer organizations in Georgia?

II. OUR TWENTY-FIVE DOLLARS

Publications

The journals published by the AMA are primarily for its members. Because the Association owns its printing plant these journals can be supplied to its members at a great saving. Yet, to give you some idea as to the enormous

amount of printing done by the Association, the overall printing bill for 1950 was \$3,174,-818.86. This does not include special printing of pamphlets and literature for the National Education Campaign.

The most familiar journals is *The Journal of the AMA*. It has been the life blood of the Association. Today it is the powerful voice of the medical profession in its fight to raise the standards of medical education and to keep medicine free.

The first publication of *The Journal* rolled from the press on July 14, 1883, and contained thirty-two pages. Three thousand to 4000 copies were being printed weekly before the first year was over. Today, 167,000 strong, it has a larger circulation than the leading ten weekly medical journals in the world combined.

The aim set forth by the founders in 1883 still remains the principle aim of today when they said "The great aim of the movement to publish a Journal would be to furnish the Association with an organ—an exponent of its principles, a medium of communication between it and its members, between the members themselves and between the Association and the profession at large." Read your Journal and you will find it full of valuable information besides the scientific articles.

ARCHIVES OF DERMATOLOGY AND SYPHILOLOGY

In 1919, through the influence of Dr. William Allen Pusey, the AMA took over the printing of the official journal of the American Dermatological Association, relieving its sponsors of a heavy financial burden. Today this Journal is recognized as the best publication on dermatology in the world.

ARCHIVES OF INTERNAL MEDICINE

In 1907 the *Archives of Internal Medicine* was started with the idea that it would bridge the space between purely scientific research and its application to practical clinical medicine. The Archives has appeared each month since its first number.

ARCHIVES OF SURGERY

Since there were several good journals on surgery printed in the United States the AMA hesitated about starting another one. There had been much debate on the subject since 1910, but the periodical did not appear until July, 1920. Today the papers published in the *Archives of Surgery* are reprinted in abstract form in foreign journals more than those of any other American journal on surgery.

AMERICAN JOURNAL OF DISEASES OF CHILDREN

After an urgent request of the outstanding pediatricians of America, the AMA began the publication of a journal on children's diseases. The first edition appeared in 1911. It is today the leader in world pediatrics.

Other monthly publications on special branches

of medicine are:

Archives of Pathology
Archives of Neurology and Psychiatry
Archives of Ophthalmology
Archives of Otolaryngology
Archives of Industrial Hygiene and Occupational Medicine

All are outstanding in their field and authentic in their presentations. Any of these journals are available to the medical profession for a nominal subscription rate.

TODAY'S HEALTH (HYGEIA)

Today's Health, formerly called *Hygeia*, is the only authentic health periodical for the laity printed in this country. At the present time it has a circulation of over 200,000 per month. It is widely quoted in the lay press and magazines. It should be in every physician's reception room.

LIBRARY OF THE AMERICAN MEDICAL ASSOCIATION

The plans for establishing a library of the American Medical Association were discussed as early as 1868. The actual formation of a library began in 1911. This library maintains a unique type of service. It is not a collection of old or new medical books. It specializes in current medical literature. It is a collection of medical periodicals, reprints, and original articles on all phases of clinical medicine. It has a ten year collection of over 1400 periodicals. This collection is for a package library service and periodical lending service. This service was established for the members of the AMA. It is your library and if you are preparing a paper or wish information on a certain medical subject contact the library in Chicago. They will help you and explain to you the workings of this unique service.

Besides this service, the AMA has many pamphlets, circulars and reprints for use by its members. Often we receive inquiries as to certain treatments, quack remedies or new drugs. You can always get the latest information from the AMA headquarters.

Quoting Editor R. H. Kempmeier of *The Journal of the Tennessee State Medical Association*: "Concerning the AMA and my dues to it. I get my \$25.00 worth. *The Journal* is first rate,—subscription price \$15.00. The remaining \$10.00 is well spent. In academic medicine I, as do all men engaged in medical science, use constantly the *Cumulative Index*, the only universal bibliographic reference,—this is published by the AMA at a loss of \$75,000 annually. I get some of my \$10.00 here. Then I commonly refer to the Special Journals of the AMA to which I can not afford a subscription, but published by the AMA at an annual loss of \$20,000.

The AMA is democratic enough for me to stay in it."

EUSTACE A. ALLEN, M.D.

A DANGEROUS BUT CURABLE DISEASE

A new but very dangerous disease is affecting the American public, and the resulting morbidity and mortality increases rapidly each year. This new ailment might be called "paradoxical complacency" or "stupid indifference" because the etiology of the disease can readily and directly be traced to a peculiar failure to function of the thinking apparatus of all of us.

The ravages of the disease may be seen on the streets and highways every day and every night all throughout the year. In fact the condition is at its worst on week-ends, holidays, vacation time, and around such special events as ball games, boxing matches and circuses. Certain aspects of the condition would classify it as a contagious disease, but it is constantly endemic involving all parts of the entire country.

This disease is due to the indifference of the average voting American citizen who permits the destruction of an increasing number of men, women and children on our streets and highways, but does nothing about it except shrug his shoulders lightly. If American doctors allowed any disease to get out of hand so completely as has the accident situation in this country, the outcry of the public would be loud enough to be heard around the globe. If the incidence of polio jumps up even a slight percentage figure, the papers carry the details of each case, children are barred from picture shows and swimming pools, travel is discouraged, investigations are started, researchers come in and we show our concern in many other ways. Yet the total number of deaths from polio in Atlanta up to now (10) does not equal one good family picnic wreck in one county in the entire state (11 are killed and eight injured). Recently I helped remove an entire family of six killed outright when the driver of a speeding truck with tractor went to sleep allowing his heavy vehicle to get on the wrong side of the highway. The death toll on the highways this past week-end was 16, and was as high as 48 in some states.

What is the cure of this disease? Do Georgians really want to do something to control this curable disease? Undoubtedly, in our right minds we all agree that something must be done to correct the causes and that it will require intelligent consideration and the active cooperation by all citizens. And by all means let us keep such activities out of the "campaign" stage because prevention and treatment of this disease must be kept up 24 hours in every day. We can not depend entirely on police officers to do the job without giving them our full support and the necessary financial assistance. Imagine the courage required of an officer to chase a car speeding up to 100 miles per hour—how many of us would have done it?

Complacency and indifference must be re-

placed by a plan of action based on correction of known weak spots that harbor the germs causing the disease. Most of them are well known to all of us and we could immediately embark on a program which would include:

1. An educational program in high schools, colleges and in the city and state highway traffic departments. The workings of a motor with attention to such factors as horsepower, braking power, and acceleration, and the movement of vehicles in roads of varying widths, clearance required for passing, effect of surface in producing skids and many other factors could be taught. It has been proved that high school students with some basic information have fewer accidents than those not instructed and that is a problem that can be handled readily by the school board in your city or county.

Schools conducted by traffic departments for adults have been found to be a great success in many cities. Attendance can be voluntary and sponsored by civic clubs who compete for maximum participation, and also offenders can be "sentenced" to a given number of hours of instruction. Truck drivers, bus operators, and similar groups could be required to demonstrate certain basic knowledge before being given the privilege of using our streets.

2. Back our traffic judges and police officials, who have a difficult job at best, by giving them your active support, ask no favors, and require them to do their duty at all times impartially.

3. Give the State Highway Police enough men and cars to enforce the speed and weight laws in our Statute Books. Patrolling is a well known deterrent to the speeder, so keep our traffic officers always in sight. Undoubtedly such a program will require more money but can that be compared to the millions lost by deaths, prolonged periods of hospitalization, and property damage?

Paraphrasing the slogan of a well known Georgia utility company, "A doctor is a citizen wherever he serves," and he will cooperate with other citizens today in their efforts to rid all Georgians of this terrible American disease.

The first number of The Journal of the Medical Association of Georgia was published in January, 1911 and the first article is entitled "The Association of Uncinariasis (Hook-Worm) in Cataracts," by Dr. F. Phinizy Calhoun, Atlanta. Other articles were presented by Dr. E. T. Gibbs, Gainesville; Dr. W. W. Battey, Jr., Augusta; Dr. Edgar G. Ballenger, Atlanta, and Dr. W. L. Champion, Atlanta.

The subscription price was \$1.00 per year and The Journal was edited by Dr. W. C. Lyle, Augusta. The program of the Sixty-second Annual Session held in Rome, April 19, 1911, is included along with District and County Society programs.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

RESPONSIBILITY FOR TUBERCULOSIS PATIENT CARE

H. C. SCHENCK, M.D., *Atlanta*

Director Division Tuberculosis Control

As to the question of who should treat and care for tuberculosis patients, the obvious answer is, "The physician." But many physicians will reply, "Why, I thought that all that is expected of me is to establish the diagnosis and have the patient admitted to a sanatorium."

It is necessary, however, for the physician to assume additional responsibilities. Of the time required for a tuberculosis patient to get well, the average case can spend only about one-fifth of it in the State or Veterans Administration tuberculosis hospitals. Or, putting it in another way, only about one-fifth of the patients can be cared for in these institutions at any one time. The remaining four-fifths must be cared for by private physicians.

To this, many doctors may reply that it is difficult for them to understand such a statement when for a long time they have been given to understand that, year after year, there is a continuing reduction in the tuberculosis death rate to the present 25 per 100,000 population in Georgia, which is apparently rapidly diminishing. To them it seems that tuberculosis is losing its importance as a preventable disease. And if it is unimportant, or speedily becoming so, why should they be urged to take even still greater interest than before?

A partial answer to this is that while the death rate has dropped the tuberculosis case incidence apparently has not increased to a similar extent. For instance, for a period of years the number of new cases reported annually in this State has been about 3,000. About 1500 new cases have been reported during the first six months of this year. One may say, therefore, that while the death rate may show proportionately the extent of the control problem in different areas, races, sexes and age groups, it does not indicate the extent of infection nor the number of living cases in these same groups.

EXTENT OF TUBERCULOUS INFECTION

To confute the idea and teaching of some that tuberculosis is fading out of the picture or that it is under control we need only to refer to the whole-sale tuberculin testing of 68,829 persons in Columbus. Here 31,541 or 46 per cent were positive to the test and this means that nearly every other person has been infected. That is a far cry from control.

By the time people reach the age of 20 years, 44

per cent of the white males, 29 per cent of the white females, 70 per cent of the non-white males, and 53 per cent of the non-white females have been infected. In the Columbus study, the percentage of infected persons ranged from about 3 per cent in white children at five years of age to 89 per cent in Negro males at 40 years of age. This testing was done last year (1950) using Purified Protein Derivative Tuberculin and no reaction measuring less than 5 mm. in diameter was listed as positive.

There is no reason to believe that the same widespread infection does not exist to a similar extent in other areas of the state. Among these infected persons are the active cases, the developing cases, the source of infection cases and future cases.

FACILITIES FOR CARE AND TREATMENT

As was mentioned above, about 3,000 new cases of tuberculosis are reported in Georgia every year. They include all types: old and young; minimal to far advanced; cases requiring little attention to those that are bedridden; rich and poor; acute and chronic; positive sputum and negative sputum—all requiring some degree of medical guidance. Many of these persons have chronic tuberculosis and may live for many years. As a result of the long duration of the disease, the existent patients always greatly exceed the number of new cases reported annually. Our Central Tuberculosis Case Register as of January 1, 1951, contained records of 9961 active and convalescent cases. This case load will be increased annually for some time to come as new cases are brought to light. It only can be decreased by cases dying, or getting well, or leaving the State, and by a diminution of the rate of development of new cases through more effective control.

How many more cases there may be in addition to those shown by our current records is not known. Estimates of the total number of cases range from 12,000 to 15,000. Be that as it may, we know that of the approximately 10,000 known cases only about 2,000 or one-fifth can be treated at any one time in the State Sanatorium (about 1700) and the Veterans Administration hospitals. This means that there are no less than about 8,000 known cases who must look to the private physician and the local community for whatever they may need in the way of patient care.

(Continued on page XVI)

THE BOOK SHELF

BOOKS REVIEWED

REVIEW of PHYSIOLOGICAL CHEMISTRY: By Harold A. Harper, Ph.D., Lecturer in Surgery, University of California School of Medicine, Polo Alto Calif. University Medical Publishers. 1951. Price \$3.50.

This volume sets out to present the fundamentals of physiological chemistry with emphasis on the accepted facts and concepts of the subject. A concise presentation of the applied and established principles has been favored over that of the theoretical and controversial; and it is intended as a supplement to the standard texts in biochemistry and as a companion volume for the student in such courses. It is also intended as a review for the physician preparing for state and specialty boards as well as to aid him in keeping abreast of the rapidly expanding knowledge in biochemistry.

The volume fulfills these ends very well. The reviewer is certain that, had Dr. Harper allowed himself more space in which to dilate, several of the statements which he had made would have been enlarged. This cannot be called a fault—it is simply a necessary feature of the review type publication. The review has been written very closely and concisely and is well illustrated with diagrams and drawings of various kinds in an attempt to clarify the more complex biochemical relationships. The breakdown of the book into 21 chapters is excellent and quite inclusive. The index has been well prepared. We hope that the table of references in the next edition will contain a more detailed reference section. As it stands in the present edition some 53 textbooks, 16 review publications and 15 journals are referred to, and no attempt has been made to present the portions of these textbooks and reviews for the particular articles or issues of the journals which the author considers especially valuable. It seems to us that this would be a helpful addition, indeed.

This book represents a valuable accompaniment to present-day biochemical publications.

DAVID F. JAMES, M.D.

CLINICAL PEDIATRIC UROLOGY: By Meredith Campbell, M.D., Professor of Urology, New York University Postgraduate Medical School, New York City. 1113 pages with 543 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price \$18.00.

As the author states in his preface, urology in

infants and children is a firmly established and increasingly active field of medicine. The unexpected high incidence of abnormalities of the urinary tract, demonstrated by excretory urogram and cystourethroscopy, has stimulated progress greatly. Modern instruments make it possible for the newborn to be studied as completely as the adult. With the advent of antibiotic medication these diagnostic procedures can be performed without the complications caused by trauma and infection.

The author is to be commended for informing the inexperienced reader with an opinion of the value derived from the many surgical procedures described. Doctor Campbell's broad personal experience in this field makes his comments worthy of profound respect. Too often, this type of book becomes a compendium which is more valuable for completeness than for guidance.

Also worthy of comment is the author's discussion of clinical urological entities which are rare, but grave in their prognosis. This type of subject he has elected to discuss in detail.

Medical illustration, expressed in the 543 figures, is of the best. The excellence of the photomicrographs, photographs, diagrams and finished drawings can only be attained by discarding a multitude of less satisfactory figures.

An example of the practical arrangement of the text is the section on surgical treatment of peno-urethral anomalies. The author first outlines the criteria of a satisfactory surgical procedure, and then evaluates the various techniques. Here, again, the illustrations are extremely good. The technical hazards are stressed for the uninitiated.

The last chapter entitled "Nephritis and Allied Diseases in Childhood," written by Doctors Goettsch and Lyttle are concise, and useful from the point of view of differential diagnosis.

The entire volume is well documented, and exemplary of skill acquired only by the experienced author.

JAMES H. SEMANS, M.D.

NEW AND NONOFFICIAL REMEDIES, The Council on Pharmacy and Chemistry, American Medical Association, J. B. Lippincott Company, Company, Philadelphia, 1951, Pp. 782.

The 1951 edition of this annual publication of the Council on Pharmacy and Chemistry of the American Medical Association includes articles which the Council has found acceptable

under its rules through the period ending January 1 of the year of publication. Essentially, the book consists of two major divisions: Section A with general statements on broad classifications of preparations, and monographs describing the actions, usage and dosage of specific articles; and Section B with physical descriptions, tests, and standards for Council accepted drugs for which official standards are not available.

EDGAR D. SHANKS, JR., M.D.

CLINICAL AND ROENTGENOLOGIC EVALUATION OF THE PELVIS IN OBSTETRICS: By Howard G. Moloy, M.D., M.Sc., Assistant Clinical Professor of Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University and The Sloane Hospital for Women. 119 pages, 68 figures. Philadelphia and London: W. B. Saunders Company. 1951. Price \$2.50.

This excellent monograph is especially valuable in that it presents, in compact form, the ideas of the one who did the most work in the obstetric evaluation of the pelvis by Caldwell, Moloy and de Esopo in the early nineteen thirties. For a hundred years prior to that time, the pelvic bony structure had been studied especially by anthropologists and by the German scientists. The former were interested primarily in ascertaining criteria for determination of sex in unknown material, while the later were interested from an obstetric view point. Although the incomparable work of Naegele, Michaelis, Litzmann, Neugebauer and many others was scientific and exact, it made pretty dry reading for the average clinical obstetrician. Caldwell, Moloy and de Esopo added the functional approach. They were exceedingly benefited by plenty of research funds, by association with outstanding scientists in related fields and by a happy fortune in choosing names for their principle classifications which gave the student a mental picture of the various types. Their classification is quite rightfully superseding in the classroom the German one promulgated for a generation by De Lee and Williams text books.

The classification, however, has been modified to include intermediate types until now it requires approximately three pages, to list, 51, 52 and 53. On page 46 is an illustration of Naegele's obliquity attributed to tuberculosis of the sacroiliac joint in childhood. A study of the Hellman and Musa translation of Naegele's monograph indicated that he considered the defect congenital and most of the recently reported instances tend to bear out this idea.

Kielland's forceps, which may in time prove to be the only truly important addition to Chamberlen's invention, is mentioned.

Moloy stresses the point that the ideal obstetrical department should have a correlated room of ample size devoted to the purpose of manikin teaching and of reviewing x-ray films while the

management of the case is fresh in the minds of those present.

This monograph should be in every medical library and in that of each obstetrician.

RICHARD TORPIN, M.D.

CLINICAL UNIPOLAR ELECTROCARDIOGRAPHY: By Bernard S. Lipman, M.D., Assistant in Medicine, Emory University School of Medicine; and Edward Massie, M.D., Assistant Professor of Clinical Medicine, Washington University School of Medicine, Director of Heart Station, Barnes Hospital, St. Louis. Pp. 250. 1951. Price \$5.00. The Year Book Publishers, Inc., 200 East Illinois Street, Chicago.

In recent years the rapid advances in the clinical use of the augmented vector leads and the unipolar chest leads, not only in the evaluation of myocardial disease but also in extracardiac and general metabolic disorders, have resulted in the need for a monograph concise enough to report these advances for clinical use. Dr. Lipman and Dr. Massie have admirably succeeded in this aim. The book is well written and the illustrations by drawings and photographs augmented the quality of the text. The bibliography is extensive. Some 63 pages of the book are devoted to illustrative unipolar electrocardiograms from the teaching file of Barnes Hospital, St. Louis.

EDGAR D. SHANKS, M.D.

LET'S COOK IT RIGHT: By Adelle Davis, published by Harcourt, Brace and Company, New York, 1947, pages 626, price \$3.00.

This new book was written with the aim of "bringing into the kitchen" nutritional knowledge that has been acquired both by nutritional research and the practical art of modern cooking. The reasons why particular foods are best cooked as described are well explained. For example, in the cooking of fish the temperature at which both fish proteins are cooked and the connective tissue is also broken down without undue loss of tissue fluids and palatability is particularly well described.

The book is designed for the cooking needs and problems of the average family and special diet problems are left undiscussed.

EDGAR D. SHANKS, JR., M.D.

LET'S HAVE HEALTHY CHILDREN: By Adelle Davis, published by Harcourt, Brace and Company, New York, 1951, pages 314, price \$3.00.

This new book by Mrs. Davis, who is a consulting nutritionist in Los Angeles, and the author of several earlier books in the field of nutrition and diet, is designed for lay reading. The book is so designed as to advise the proper diet of the expectant mother and the proper feeding care of the infant and growing child.

EDGAR D. SHANKS, JR., M.D.

OF GENERAL MEDICAL INTEREST

CALENDAR OF MEETINGS

THIRD ANNUAL E. C. DAVIS MEMORIAL OBSTETRICAL LECTURESHIP, Academy of Medicine, October 4. Dr. James H. Byram, Atlanta, Secretary.

SECOND ANNUAL STATEWIDE MEDICAL PRESS AND RADIO CONFERENCE AND DINNER under the auspices of the Medical Association of Georgia on Friday, October 26, in the Walter Little Room of the Dempsey Hotel, Macon.

FOURTH ANNUAL POSTGRADUATE COURSE FOR GENERAL PRACTITIONERS, October 8-12, sponsored by Emory University School of Medicine and the Medical Association of Georgia. Dr. Russell H. Oppenheimer, 36 Butler St., S. E., Atlanta, Director.

GEORGIA CHAPTER OF AMERICAN ACADEMY OF GENERAL PRACTICE, Idle Hour Country Club, Macon, October 25. Dr. Walter W. Daniel, 743 West Peachtree St., N. E., Atlanta, President. (See program page IX).

GEORGIA CHAPTER AMERICAN COLLEGE OF SURGEONS, Bon Air Hotel, Augusta, October 18. Dr. James H. Semans, 34 7th Street, N. E., Atlanta, Acting Secretary. (See program page X).

GEORGIA PEDIATRIC SOCIETY, ACADEMY OF MEDICINE, Atlanta, October 11. Dr. Harry Lange, 490 Peachtree St., N. E., Atlanta, Secretary.

GEORGIA RADIOLOGICAL SOCIETY, Bon Air Hotel, Augusta, October 18. Dr. Robert Pendergrass, Americus, Secretary.

GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY, Augusta, October 18. Dr. Jule C. Neal, Jr., 203 Professional Building, Macon, Secretary.

GEORGIA STATE SOCIETY OF ANESTHESIOLOGISTS, Bon Air Hotel, Augusta, October 18. Dr. Perry Volpitto, University Hospital, Augusta, Secretary.

GEORGIA UROLOGICAL ASSOCIATION, Bon Air Hotel, Augusta, October 18. Dr. J. Z. McDaniel, C. & S. Bank Bldg., Albany, Secretary.

SOUTHERN MEDICAL ASSOCIATION, Dallas, Texas, November 5-8. Dr. C. P. Loran, Secretary-Manager, Empire Building, Birmingham 3, Ala.

DISTRICT AND COUNTY MEDICAL SOCIETIES

SEPTEMBER 25: Fourth District Medical Society, LaGrange, 7:00 p.m.

SEPTEMBER 26: Seventh District Medical Society, Cedartown, 2:00 p.m.

SEPTEMBER 26: Ninth District Medical Society, Jasper, 3:00 p.m.

OCTOBER 4: Second District Medical Society, Thomasville, 3:00 p.m.

OCTOBER 6-7: Eighth District Medical Society, King and Prince Hotel, St. Simons Island.

NOVEMBER 15: Fifth District Medical Society, Atlanta, Dr. L. Minor Blackford, Secretary.

DECEMBER 5: Sixth District Medical Society, Macon, 2:00 p.m.

Calling attention to the fact that in Wilcox County, 35 per cent of all babies born in one year were delivered by midwives, Dr. V. L. Harris, president of the county medical society, gave high praise to plans for the first midwives institute, which was held in Cordele August 2 and 3.

About 50 or 60 midwives from Wilcox and seven nearby counties attended. Public health nurses from eight counties, including Mrs. Bessie Lee Horne, planned the program, and participated in the teaching. Demonstrations were given under direction of public health doctors and consultant and nutritionists from the state and regional health departments.

"This teaching institute is a new part of the Georgia pattern in which public health nurses and physicians work closely with midwives," Dr. Harris said.

Drs. H. A. Seaman and Floyd Davis, both of Waycross, were hosts to the Ware County Medical Society on August 2. The membership of Dr. Neal Yeomans who entered practice in Waycross as a radiologist, was transferred from the Richmond County Medical Society.

The Tenth District Medical Society met at Washington August 23, with the following scientific program: "X-Ray Diagnosis of Various Gastrointestinal Conditions," Dr. Stephen W. Brown; "Medical Aspects of Various Gastrointestinal Conditions," Dr. Charles W. Hock; and "Surgical Aspects of Various Gastrointestinal Conditions," Dr. J. H. Sherman, all of Augusta.

The following officers for 1952 were elected: President, Dr. David R. Thomas, Jr., Augusta; Vice-President, Dr. Marion A. Hubert, Athens; and Secretary-Treasurer, Dr. A. W. Simpson, Jr., Washington.

Following dinner, many members participated in a golf tournament.

ANNOUNCEMENTS

The College of American Pathologists announced the organization of a program to improve the efficiency and to increase the uniformity of medical laboratory analyses. At first this program will function primarily in supplying highly standardized and very accurate solutions that will enable small and large pathology laboratories to develop and maintain uniformly reliable test solutions in the field of chemical determinations. Other branches of medical laboratory work will soon be included in the scope of activities if present plans are continued.

THE AMERICAN GOITER ASSOCIATION again offers the Van Meter Prize Award of Three Hundred Dollars and two original honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association in Saint Louis, Missouri, May 1, 1952, providing essays of sufficient merit are presented in competition. For further information, write to this office.

THE 1951 DIABETES DETECTION DRIVE will be launched by Diabetes Week—November 11-17—and is sponsored by the American Diabetes Association. One hundred per cent cooperation of all State Medical Societies in this year's program is essential to its success.

THE FORUM ON FUNDAMENTAL SURGICAL PROBLEMS, designed to bring out the best of what is new in surgery and give younger surgeons doing original work a chance to be heard, constitutes one of the most interesting portions of the program for the thirty-seventh Clinical Congress of the American College of Surgeons to be held in San Francisco. Dr. Owen H. Wangenstein, University of Minnesota Medical School, is Forum chairman.

Better vision programs as a tool for gearing up defense production and reducing man-hour loss will be stressed at the 4th annual Occupational Vision Congress at Georgia Tech in Atlanta, October 4 and 5.

This will be sponsored by the Engineering Extension Division, Georgia Institute of Technology; the Associated Industries of Georgia; the Cotton Manufacturers Association of Georgia; the Georgia Industrial Nurses Association; The Georgia Optometric Association, the Georgia Society of Ophthalmology; the Industrial Hygiene Division, State Department of Public Health; and the Illuminating Engineering Society.

The sixth annual postgraduate course on diseases of the chest, sponsored by the American College of Chest Physicians, cooperating with staff members of the medical schools and hospitals of Chicago will meet at the St. Clair Hotel, Chicago, on September 24-28.

DEATHS

AULT: *Dr. Henry Jason Ault*, 75, of Dalton, died August 8 after suffering a cerebral hemorrhage at his office. An eye, ear, nose and throat specialist, he was graduated in 1905 from the Atlanta College of Physicians and Surgeons, and also studied at Johns Hopkins, Tulane and Vanderbilt Universities and in New York. He practiced in Mt. Vernon for three years, then moved to Dalton, where he first engaged in general practice, then concentrated in eye-ear-nose-and-throat. Dr. Ault was a founder of Hamilton Memorial Hospital, Dalton, and a past president and secretary-treasurer of Whitfield County Medical Society.

COPELAND: *Dr. Henry W. Copeland*, 73, Griffin physician, died June 4, of acute myocardial insufficiency. Graduate of Atlanta College of Physicians and Surgeons, 1901, member of the Medical Association of Georgia and the American Medical Association.

GAY: *Dr. Joseph Reid Gay*, 54, distinguished Waycross physician and a native of Wrens, died in the Veteran's Hospital, Dublin, August 20. A graduate of the University of Georgia School of Medicine, Augusta, in 1935, he practiced medicine in Homerville before moving to Waycross in 1943, to practice internal medicine and cardiography. He was a past president of the Ware County Medical Society.

GARRETT: *Dr. John Abner Garrett*, 71, of Meigs, died June 6 after a brief illness. A 1906 graduate of the Atlanta College of Physicians and Surgeons, Atlanta.

HARBER: *Dr. George Dillard Harber*, 43, formerly of Commerce, died August 4 following a heart attack in Chicago. He was graduated from Emory University School of Medicine.

MOORE: *Dr. Robert Foss Moore*, 33, died in an Albany hospital August 11 of injuries received six hours before when his automobile collided with a truck near Newton. He had only recently moved from Nashville to Donaldsonville to establish a practice. He also had practiced in Warrenton. A native of Richmond County, Dr. Moore was a graduate of the Medical College of Georgia, Augusta.

PAULLIN: *Dr. James Edgar Paullin*, 69, Atlanta, died August 13 (see page 388).

FUCKETT: *Dr. William M. Puckett*, 75, died at his home in Irwinton on August 8. A 1912 graduate of the Georgia College of Eclectic Medicine and Surgery, Atlanta, he had practiced in Montrose, Millwood and Thomaston before moving to Irwinton in 1931. He had

been active in practice until about three months before his death.

QUILLIAN: *Dr. Garnett Wiley Quillian*, 67, a native of Atlanta, died at his home in Arlington, Va., August 31. A 1909 graduate of Emory University School of Medicine, Atlanta, he practiced surgery in Atlanta with his brother, Dr. W. Earl Quillian until his retirement 15 years ago because of ill health.

WOODROOF: *Dr. William Lowe Woodroof*, 70, Newnan, died August 27. A 1912 graduate of Atlanta College of Physicians and Surgeons, Atlanta.

CORRESPONDENCE

To The Editor:

I wish to extend through you to the Medical Association of Georgia, my sincere appreciation and warmest thanks for the Certificate of Distinction and the beautiful 50 year pin which I received yesterday.

Forty-one of these 50 years have been spent happily and, I hope, profitably in Georgia; and the memories of practice in the years to come are of the very pleasantest.

With kindest regards, I am

Yours very sincerely,

GEORGE S. MURRAY, M.D.

To The Editor: I would like to express my appreciation for the Certificate of Distinction and Fifty Year Pin which were given to me by the Medical Association of Georgia.

P. WILLSON, M.D.

To The Editor: The certificate and caduceus the Medical Association of Georgia so kindly presented to me has been received. I want to thank the Society through you for this notice having been taken of me.

W. L. COOKE, M.D.

MEDICAL COLLEGES

Dr. William E. Barfield is with the department of endocrinology of the Medical College of Georgia, in Augusta, where he has a research fellowship in endocrinology, obstetrics and gynecology.

Dr. W. A. Mickle, Jr. is assistant professor of anatomy in the Emory Medical School.

Dr. Lombard Kelly will ask the next general assembly to pass a bill requiring medical graduates to serve a two-year internship.

Governor Talmadge said a plan for a two-year training course for Georgia medical graduates met with his "full approval."

Dr. William C. McGarity is an instructor in the department of surgery at Emory University Hospital.

"Part Time Anesthesiologists in the State of North Carolina" will be the theme of the scientific program for the Annual Meeting of the North Carolina Society of Anesthesiologists which will meet in Charlotte on October 2, 1951. Tentative speakers on the program include Dr. Perry P. Volpitto, Augusta, of the University of the Georgia Medical School.

Students in the Emory University School of Medicine, Atlanta, are going to learn about the life of a country doctor in the best way possible . . . by living it.

Under a new program, announced recently by Dean Hugh R. Wood, selected seniors will study for a month with a general practitioner outside the metropolitan area of Atlanta. They will ride with him on his rounds, help him with his records, and perhaps lend a hand with a steering wheel or a stethoscope.

Various "new drugs" used in the treatment of tuberculosis will be evaluated under more than a dozen of the grants awarded by the National Institutes of Health, in Washington.

Grants in Georgia went to (1) J. M. Dalla Valle, Georgia Institute of Technology, Atlanta, an investigation of the effect of minute quantities of chemical vapors on bacteria and spores, \$23,652.00; (2) Paul B. Beeson, M.D., Grady Hospital, Atlanta, Leptospirosis meningitis, \$6,445.00, and (3) Walter H. Sheldon, M.D., and Albert Heyman, M.D., Emory University School of Medicine, Atlanta. The determination of the distribution of spirochetal antigen in cells by fluorescent antibody, \$13,316.00.

GEORGIA PRESS COMMENTS

Watch for Those Kinfolks!

Chairman of the Fulton-DeKalb County Hospital Authority and prominent lawyer, Mr. Spalding, laid on the line the basic principles that make a going hospital out of a mere stack of bricks and plumbing.

From the moment he said "Don't let the politicians fill your hospital with kinfolks," the audience realized it was in for a speech on fundamentals, the questions that have to be decided before a hospital, no matter how complete its physical plant, becomes an institution for service and public benefit.

He cited:

Separation of medical and administrative policy;

Reliance on the administrator without interference;

Refusal to accept terminal illness cases or cases requiring long hospital convalescence.

Clear policy on charity patients and definition of charity patients.

All of Mr. Spalding's points were well made and convincing.—*Gainesville Daily Times*.

An Overlooked Attraction

One of Carrollton's greatest assets in the way of drawing people to the city from distances is her talented group of medical, surgical and dental practitioners and their excellent facilities, including Tanner Memorial Hospital.—*Carrollton Free Press and News*.

Freedom For All

"This answer to the problem of medical care will not be found in any political panacea or through the development of a super bureaucracy. The answer to the problem will be neither simple nor easy, but it will be found within the framework of our present economic system and our present constitutional safeguards."

That wasn't said by a spokesman for the medical fraternity. Instead, it was recently said by one of the most aggressive labor leaders in the country—*Dave Beck, Executive Vice President of the International Brotherhood of Teamsters*. He then added, "The answer as proposed by advocates of government-controlled medicine is contrary to our economic structure and goes beyond our traditional guarantees. Any system which proposes such modifications in our way of living and doing things would lead to a dangerous socialistic trend and cannot be tolerated. Such a system would destroy our liberty."—*The Madisonian*.

Hospitalization and Income Protection

We have been against socialism from the first. There never has been a land or country where any of the schemes of socialism actually worked out so that it could be used as an example. Wherever socialism has been tried the nation was made poorer and the so-called leveling process only took off the heads of the best people and left only the problems for future study.

But we are for any prepaid hospitalization and income protection program that people enter voluntarily and pay for themselves. It is but another illustration of the fact that people can work together.—*Lawrenceville News-Herald*.

Insurance Survey To Begin Here

The Monroe Voluntary Way group hospital, surgical and medical insurance group will begin in Monroe County immediately. Each individual of Monroe County will be contacted by the authorized enrollment officers, which will feature the Georgia Plan. This is a program of surgical, medical and maternity care which is endorsed and sponsored by the Medical Association of Georgia.—*Monroe Advertiser*.

Would anyone having old copies of The Journal donate them to us? We have too few on hand.—Ed.

CLINICAL HEADLINES

New Drug Being Tested by Army May Provide Rapid Cure for Malaria

A rapid cure for malaria may be provided by a new drug, primaquine, now being tested extensively in the field. Tests already conducted indicate that primaquine may be a far more effective treatment for malaria than any other drug now in use, according to the Army Surgeon General. He emphasized, however, that further research is necessary to determine whether it will prove as effective against the strain of malaria found in Korea as it has against experimental strains.

Frozen Orange Juice On Par With Fresh

Frozen concentrated orange juice now accounts for approximately 35 per cent of all frozen food sales, according to the Council on Foods and Nutrition of the AMA. In a recent report the Council holds "that frozen concentrated orange juice made from properly selected and prepared fruit is a dependable source of vitamin C and that it may be useful in the diets of persons of all ages."

Armour's New Surgical Aid, Tryptar

The action of Armour's new surgical aid, Tryptar, has been portrayed in a color film which shows several important uses found for trypsin in clearing infected and necrotic tissue—in tuberculous empyema, in burns, in superficial ulcers—and will also picture test tube work demonstrating the effectiveness of the newly available drug.

Motion Pictures on Health

A revised list of "Sources of Motion Pictures on Health" has been prepared by the Committee on Medical Motion Pictures of the American Medical Association. This new mimeographed list includes 9 pages of addresses of the major loan and rental libraries, the state health department's film libraries and references to printed lists and catalogs. Copies are available from this office.

PERSONALS

Transition

DR. E. A. BARGERON—resumed practice in Waynesboro.

DR. IRWIN BLUMENTHAL—native of Royston, lately in residency in Cincinnati, Ohio, has moved to Atlanta to practice.

DR. VINCENT J. CIRINCIONE—opened office, 1 West Duffy St., Savannah, Dermatology.

DR. WARREN UPTON CLARY—opened office, 513 Whitaker St., Savannah. Neurosurgery.

DR. M. B. COPELOFF—Atlanta, appointed medical director of the Jewish Home for the Aged, scheduled to open this fall.

DR. JOHN K. DAVIDSON, III—associated with

Dr. H. Haywood Turner, II, Columbus. Internal medicine.

DR. M. BEDFORD DAVIS, JR.—opened office, 1083 W. Peachtree St., Atlanta. Thoracic surgery.

DR. A. W. DeLoach—of Savannah, opened office in Cairo. General.

DR. GEORGE P. DILLARD—formerly of North Carolina, erstwhile medical missionary, opened office in Austell. General.

DR. OLIVER T. GHENT—native of Canada, became radiologist at new Hall County Hospital, Gainesville.

DR. FRANK LESLIE GIBSON—formerly resident in surgery at Grady Hospital, Atlanta, entered practice, Riverside Hospital, Bainbridge.

DR. SAMUEL A. HEATON, JR., a native of Augusta, announces the opening of his offices for the practice of medicine at Hartwell.

DR. GEORGE T. HENRY—opened office in Barnesville. General. (The August 1951 JOURNAL incorrectly listed Dr. Henry's location as Bainbridge.)

DR. HENRY S. JENNINGS, JR.—associated with the Private Diagnostic Clinic, Emory University Hospital. Internal medicine.

DR. LAWSON JOHNSON—joined his father and brother, Drs. James A. Johnson, Sr., and James A. Johnson, Jr., in general practice, Manchester.

DR. DAVID McKEE—associated with Drs. Lewis D. Hoppe and James P. Hanner, Medical Arts Building, Atlanta. Pediatrics.

DR. J. DOUGLAS McREE—Unadilla, moved office to the Wendel Collins home, where he is installing a delivery room and will have a small clinic.

DR. ROBERT EUGENE MILLER—native of Virginia, formerly of Baltimore, joined staff of Leaphart Clinic, Jesup. Anesthesiology and general.

DR. JULIAN B. NEEL—formerly of Charlotte, N. C., opened office in Thomasville. Surgery.

DR. GEORGE S. PILCHER—1950 graduate of Medical College of Georgia, entered practice in Louisville. General.

DR. HOLLIS E. PUCKETT—native of Louisville, Ky., opened office, 118 E. Hall St., Savannah. General.

DR. A. R. SIMS, Richland, announces the removal of his offices to the Peoples Bank Building, Richland, for the practice of medicine.

DR. JAMES L. SYKES—opened office, 1006½ Montgomery St., Savannah. General.

DR. IRVING VICTOR—formerly of St. Paul, Minn., opened office, 228 E. Huntingdon St., Savannah. Urology.

DR. JOHN A. WARD—1950 graduate of Emory University School of Medicine, entered practice in Shellman.

DR. W. D. WILLCOX—moved from Ocilla to Fitzgerald and resumed full-time practice.

DR. GEORGE R. GISH, JR.—announces his association with Dr. Edgar F. Fincher and Dr. Homer S. Swanson in the practice of neurologic

surgery, Emory University Hospital, Emory University.

DR. THOMAS J. VAN SANT, JR.—of Dalton has joined Dr. W. H. Benson to practice internal medicine, Marietta.

DR. WILLIAM WOOD ORR is in the practice of pediatrics in Macon.

DR. EDWARDS C. WHATLEY is in practice in Reynolds, and is associated with Dr. Sams.

DR. R. L. BLACKMON is medical director of the Chevrolet-Fisher Body Division of General Motors Corp., Atlanta.

DR. J. LON KING, JR. is practicing in Macon, where he has offices in the Persons Building.

DR. A. CULLEN RICHARDSON, JR. is associated with Dr. George A. Williams in the practice of obstetrics and gynecology with offices in the Medical Arts Building, in Atlanta.

DR. W. GROOVER SKIPPER is in private practice in Columbus. General.

In Uniform

Recently reporting for duty at Brooke Army Medical Center, Fort Sam Houston, Tex., for a year's medical internship were: FIRST LTS. HENRY W. BAILEY, Augusta; GEORGE F. GREEN, Bostwick; WILLIAM R. HOWARD, Milledgeville, and DEARING A. NASH, Savannah.

CAPT. WILLIAM J. DEAN, a 1948 graduate of Emory University School of Medicine, in August reported for duty as professor of Military science and tactics in the Emory medical School. Veteran of a year's service in Korea, Dr. Dean previously had been in residence at Grady Hospital, Atlanta.

LT. (JG) and Mrs. HUGH HASTON, JR., announce the birth of a son, Hugh Brady, in Orangeburg, S. C., on Aug. 2. Dr. Haston is serving with the First Marine Corps Division medical unit in Korea.

CAPT. WILKS O. HIATT, JR., Savannah, has reported for duty as a medical officer with the Air Force's new Air Research and Development Command headquarters in Baltimore.

FIRST LT. CALVIN MEEKS, Douglas, a graduate of the Medical College of Georgia, has arrived in Japan, where he is serving as a medical officer with a fighter-interceptor wing.

Helpmeets

DR. AVARY MILLER DIMMOCK and Mrs. Alice Downs, both of Atlanta—married June 1.

DR. JAMES T. MCCANLESS, Canton and Greenville, S. C., and Miss Nanette Baylis, Savannah—engaged to be married in September.

DR. WALTER WILSON OTTO, Savannah, and Miss Rhea LaPierre Cummings, Montgomery, Ala.—engaged to be married in September.

DR. CLARENCE J. SAPP, Rome, and Miss Hilda Christian, Albany—engaged to be married in the fall.

DR. WILLIAM COTTLES SHIRLEY, Macon, and Miss Bess Baxter, Louisville—married July 29 in Louisville.

DR. LEWIS ROSS WHATLEY, Cartersville, and Miss Dorothea Jeane White, New York City—married July 14 in Atlanta.

Progeny

TO DR. AND MRS. ERNEST L. ABERNATHY, Atlanta, a daughter, Carol Ann, April 2.

TO DR. AND MRS. MERRILL I. LINEBACK, a daughter, June 22. Dr. Lineback is in training in Boston, Mass. (ENT).

TO DR. LINDSEY F. LOVETT AND MRS. LOVETT (DR. KATHRYN SIMMONS LUNCEFORD LOVETT), Metter, a daughter, Cathy Corinne, May 7, in Atlanta.

TO DR. AND MRS. CAREY A. MICKEL, JR., Elberton, a son, Carey Alston, III, June 20.

TO DR. FERRELL SAMS, JR., AND MRS. SAMS (DR. HELEN FLETCHER SAMS), Fayetteville, a daughter, Ellen, June 13.

TO DR. AND MRS. H. LUTEN TEATE, JR., Atlanta and Decatur, a daughter, Susan Frances, Feb. 27.

Miscellany

DR. H. B. JENKINS, of Donalsonville, reported recently to the Donalsonville Lions Club on the six-week trip he and Mrs. Jenkins had just made through the West and to Canada and Alaska.

DR. C. B. LORD, Jefferson, has returned after undergoing treatment for several weeks at the Mayo Clinic, Rochester, Minn.

DR. R. M. SEALEY has returned to his practice in Atlanta after taking an eight-month postgraduate course in surgery at the University of Michigan. He is associated with DR. B. L. SHACKLEFORD.

A father, his daughter and his son-in-law, all M.D.'s, now practice medicine together in Metter. This most unusual situation came about when DR. W. E. SIMMONS was joined in July by DR. KATHRYN SIMMONS LOVETT, his daughter, and DR. L. F. LOVETT, her husband. Both Drs. Lovett are graduates of the Emory University School of Medicine and had practiced in Tate before going to Metter. The three physicians have offices and a clinic on North Lewis Street.

DR. A. W. VICKERS, Sparta, celebrated his 91st birthday anniversary on July 28.

DR. R. L. WHIPPLE, Cochran, who is still actively engaged in practice, observed his 78th birthday anniversary August 12.

DR. JOSEPH D. WODDAIL narrowly escaped death on July 29 when a drunken or crazed gunman opened fire on passing automobiles near Cusseta. One of the bullets went through Dr. Woddail's hat.

DR. HERBERT U. KING, of Dalton, has been named to a committee on tuberculosis in Georgia. The committee is composed jointly of members from the Georgia Health Officers Association and the Georgia Tuberculosis Association.

Dr. Sam E. Patton, Macon, is chairman, and serving a vice chairman is Dr. John Venable, health commissioner of Griffin.

DR. W. R. MCCOY of Folkston, recently attended a special two weeks course in obstetrics and the discases of children in Saluda, N. C.

Your attention is called to an excellent article in the August issue of *Today's Health* entitled "Breast Feeding" written by DR. HOWARD J. MORRISON, Savannah. He seems to have arranged a timely front cover in keeping with the subject matter in the article.

DR. ROBERT C. PENDERGRASS, Americus, recently was guest speaker at the Americus Rotary Club and discussed the causes and progress in treatment of cancer.

HOSPITAL NEWS

The almost-\$30,000 a year that the county has pumped into the HALL COUNTY MEMORIAL HOSPITAL might have been saved the taxpayers if the more than 1300 people who owed money paid their bills. In one fell swoop more than \$28,000 was written off the books and charged as "charity patients."

We must remember that all these people are not actually charity patients. They just didn't pay. No one checked their incomes, their financial status, their ability to pay, or the ability of their families to pay.

A list of 1500 Hall names who, to all intents and purposes, got free medical care at the expense of the taxpayers could be a terribly damning article.

Few life-long residents of this area could scan a list of 1500 names without finding a few kinfolk or, at the very least, some close friends or "kissing cousins." The hospital operates on the taxes of every citizens and the hospital is every citizen's business.

The grand jury's recommendation for a thorough investigation of the hospital appears well founded in fact. We should have such an investigation.—*The Gainesville Daily Times*.

THE ESTABLISHMENT of a Psychology Department at Milledgeville State Hospital and the addition of six members to the medical staff has been announced by Dr. T. G. Peacock, superintendent.

Heading the newly founded Psychology Department is Dr. P. G. Cranford, who will serve as its director and as chief clinical psychologist. Also serving is John Thomas Rowell, candidate for a Ph.D. degree at Florida State University.

Other new doctors at the hospital include Dr. Richard Jones, formerly with Scott Hospital, Milledgeville; Dr. W. T. Smith, Brooke Army Hospital, Ft. Houston, Tex., and Dr. James Bough, of Milledgeville.

Four of the nine additions to the staff will fill vacancies created by recent resignations. Dr.

Stewart Prather, who has been in charge of x-ray at the institution is now in Augusta for further study in radiology. Dr. George B. Strother has accepted a post with the Veterans Hospital in Roanoke, Va. Dr. W. P. Smith has entered private practice in Newnan, and Dr. Ed Leaphart has entered private practice in Jesup.

THE MEMORIAL HOSPITAL at West Point recently began a new type of service in the form of a Doctor's Telephone Exchange. The new service is the first of its kind to serve the Valley, designed to help the public locate a doctor more quickly when medical attention is needed and is operated on a 24-hour basis.

Valley doctors register at the hospital switchboard and keep the operator there posted of their whereabouts. Messages are relayed to the doctor as he checks in with the hospital exchange. In case of emergency, the operator will know where the different doctors can be reached at all times.

In announcing this new service, Burton Battle, administrator for the hospital, said:

"The work entailed in maintaining the Doctors Telephone Exchange will be great, but we feel that the service rendered on the part of the hospital will outweigh any additional work incurred.

No fee will be charged either the doctor or the public for this service which should be in operation immediately.

Open house was observed at POLK GENERAL HOSPITAL to celebrate the completion and opening of the recently constructed wing on the south side.

Completed at the cost of approximately \$70,000, the wing and improvements were made possible by a contribution from Mrs. J. T. Bright. The wing was dedicated to and in memory of J. T. Bright, Dr. George Sewell, and Dr. Seals Whitely.

President Kelly of the MEDICAL COLLEGE OF GEORGIA and its faculty members met with Dr. T. G. Peacock to lay plans for improvements at the State Hospital for admission of the Jones Hospital Building into the approved class of the American Medical Association so young doctors may do their internships and residencies at the State Hospital.

The approval by the AMA would make possible the admission of doctors to do their intern and residence work at the institution thereby providing doctors sorely needed for the staff of the world's second largest hospital.

Governor Talmadge gave the plan his approval and directed the medical college staff and the hospital staff to go forward with their plans.

Attending the conference with Dr. Peacock and his staff were Dr. Lombard Kelly, Augus-

ta; Dr. Richard Torpin, Dr. Hoke Wammock, Dr. H. E. Nieburgs, Dr. Robert Ellison, Dr. J. M. Bazemore, Dr. W. S. Flanagan, Dr. V. P. Sydenstricker, Dr. C. H. Carter, Dr. David Williams, Jr., all of Augusta, Dr. J. B. Stewart and Dr. John I. Hall, practitioners of Macon.

There have been four staff meetings at THOMASTON's new 92-bed hospital since it opened. Dr. Fred Hodges, Atlanta proctologist had the honor of being the speaker at the first staff meeting. He discussed "Postoperative Rectal Pain."

Dr. F. D. Mullins, Jr., of Athens, pathologist for The Upson County Hospital, was the next speaker. His subject was "The Various Stages of Cancer of the Uterus." Dr. J. Benham Stewart, Macon, presided at the next meeting. He discussed "Gallbladder Diseases". Dr. A. H. Letton, Atlanta surgeon, was guest speaker at the most recent meeting. He gave a discussion of "Postoperative Complications".

THE LEAPHART HOSPITAL, JESUP, announces major additions are being made both in plant and personnel. Four new doctors have been added to the staff and 18 new rooms have been built to care for the increasing number of patients. The new physicians are: Dr. Robert Miller, Baltimore, anesthetist, obstetrician and general practitioner; Dr. E. J. Virusky, Baltimore, staff surgeon; Dr. W. H. Perkins, internal medicine and Dr. E. C. Leaphart, bone specialist, who practiced in Jesup several years ago. Dr. Una Ritch Yeomans is active in pediatrics after a leave of absence.

THE MACON HOSPITAL, Macon, plans to increase the number of practical nurses, according to a recent announcement by Dr. C. L. Ridley, superintendent. He also announced a training program for practical nurses to be set up at the hospital in September, to supply helpers for graduate nurses. The hospital plans to enroll 15 or 20 girls to train them for work to ease the shortage of graduate nurses.

Hospital Benefits Expansion Slated

A chance for subscribers to expand their benefits from the Hospital Service Association of Savannah to cover surgery and obstetrics will be afforded in about 60 days through the formation of Physicians Service Association, Incorporated, according to H. B. Coolidge, executive director of the new group.

The Physicians Association recently held its organizational meeting after Dr. Ralph O. Bowden announced the granting of its charter.

At the organizational meeting last night of the physicians' group Dr. Bowden was elected president, Dr. John L. Elliott, vice president; Miss Lucile Justice, secretary, and H. B. Coolidge, treasurer and executive director.

Named to the board of directors of the asso-

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Editorials

"No man starting out need ever go over the road in the dark, if he take with him the light of other men's experience."—JOHN WANAMAKER.

EWING BRANDS "HEARTLESS" THOSE OPPOSING HIS SCHEME

Last year's elections throughout the country ostensibly dealt knock-out blows at the dominant Congressional faction who would socialize American medicine. In doing so, however, the successful results have appeared to lull physicians into the unrealistic attitude that the issue of so-called socialized medicine is a "dead duck," a finished affair.

Today, the government propaganda mills continue to grind out chilling facts and figures in indirect support of compulsory health insurance and the American public is incessantly bombarded with frightening descriptions of an existing doctor "shortage" and of urgently-needed health programs, necessitated, it is usually said, by the present national emergency.

Probably the *piece de resistance* of the summer was the recent proposal of Federal Security Administrator Oscar Ewing to inaugurate a system of hospitalization for the aged, a story which received front-page prominence in newspapers throughout the country.

Under the proposal, all persons 65 and over (including their dependents) who are eligible

for social security cash benefits would be entitled to sixty days free hospital care per year, this to include widows under 65 when the dependent children and all other survivors. Ewing added that the federal government would reimburse the hospitals for the services, drugs and appliances which they customarily furnish their bed patients. Specifically excluded in the plan, however, would be *medical care, except that generally furnished as an essential part of hospital care for bed patients*, he explained. That is, of course, unless the beneficiary was willing to pay the difference.

Ewing stated that his agency regarded this hospitalization as the insured right of all eligibles. And as accommodations now available could not handle the load, it would be taken for granted that additional hospital facilities would be financed at the taxpayers expense. The cost of the project, according to Ewing, would come out of present social "security" collections from employers and employees and would not constitute use of funds legally earmarked or committed for other purposes.

Physicians superficially perusing the proposal in their local newspapers may have tended to interpret the item that hospitals would now have

a "go" at the sort of battle against federal domination from which they, the doctors, only recently and "successfully" emerged.

Such interpretation unfortunately would have been fallacious. A careful study of Ewing's proposal would have revealed several easily-overlooked stipulations affecting the medical profession: (1) A patient would not be eligible for hospitalization until a *physician* had certified that such was necessary, (2) it would fall to the *physician* to decide when a chronic case, ineligible for hospitalization, became an acute case and therefore eligible and (3) the *physician* himself would perforce make arrangements for placing the patient in a hospital if space could be found.

In short, to physicians would fall the dirty job of screening admissions, not to mention its even worse concomitant of receiving all the blame and ill will which would inevitably arise.

When questioned if he thought there would be opposition to his proposal, Ewing magnanimously remarked, "I can't conceive that anyone with a heart would oppose this. This is something they would have paid for themselves in insurance . . . I can't believe doctors don't want sick people to have attention."

To date, neither hospital administrators nor physicians have voiced appreciable opposition to this new proposal, representing outright federal encroachment on traditionally free professions.

With reference to his comments on the matter, Ewing perhaps takes this silence on the part of both groups as an indication of their "having a heart" this year.

On the other hand, it might be well if physicians were to take the incident as indicative of their urgent responsibility to "wax heartless" again before it's too late.

CIVIL DEFENSE LEADERSHIP

A VITAL MEDICAL RESPONSIBILITY

Elsewhere in this issue there appears a reference article which outlines the work of the Medical Civilian Preparedness Committee since its creation two years ago. It attempts to bring the members of the Association up to date on developments in civil defense, and suggests how every physician can assist in the crucial civil defense tasks ahead. It is suggested that this article be kept for constant reference.

Physicians were the first to recognize and call attention to the urgent need for civil defense planning on a nationwide basis. The public instinctively expects physicians to play a leading role in this connection, and derives much peace of mind in this assurance. The American Medical Association is constantly urging its membership to assume these leadership responsibilities.

Civil defense planning entered a new phase with the establishment in December 1950 of the Office

of Civil Defense Administration directly under the President and the appointment of Mr. Millard Caldwell Jr., formerly Governor of Florida, as administrator. In Georgia this phase was reached on February 19, 1951, when the Governor signed the Georgia Civil Defense Act of 1951 which officially set up the Civil Defense Division of the Department of Public Defense. Major General Ernest Vandiver, the Adjutant General, became the director and Brigadier General Frank A. Kopf was appointed the Deputy Director of the State Civil Defense Division. The over-all Civil Defense Plan for Georgia was released in June 1951.

A summary of the main provisions of the Act is outlined in the article. It is seen that in time of emergency the Governor is given virtually dictatorial powers and can commandeer the services of any personnel needed to meet the disaster as well as appropriate any property required for this purpose, with settlement procedures to be taken care of later. The Act provides for the establishment of local civil defense organizations for communities of 1000 or more in population and for other areas determined to be strategically located. This has been accomplished and approximately 200 local defense administrators have been appointed.

The article gives the state organization charts of concern to physicians including a detailed list of the medical service branch organization and the names of those responsible for the different services. Dr. T. F. Sellers, State Health Director, has been appointed Director of the State Health Service Division, and Dr. L. M. Petrie Deputy Director has been appointed in charge of administration. Private practitioners of medicine and allied professional personnel have been placed in charge of all clinical services. This pattern is suggested as a guide for local communities.

It is emphasized repeatedly that civil defense is primarily a local civilian responsibility and that the state organization exists for purposes of coordination and directing aid when local communities are involved in disasters greater than they can handle with their own resources. From the Health Division standpoint this means that we operate on the assumption that all medical, allied and auxiliary personnel are automatically members of their respective County Civil Defense Volunteer Medical Service Corps and the different units of the State Civil Defense Volunteer Medical Service Corps, selection of which is outlined in the article, are to be highly mobile for service wherever directed by the State Civil Defense Director.

Local health and medical services can profit much by the prolonged study in civil defense planning for the Atlanta metropolitan area that is being conducted by Dr. Charles Eberhart and his committee. Essentially the community medical and health services are being organized around the public school buildings which will serve as first-aid stations, collecting points and improvised hospitals

in case of disaster. Housewives and other school district personnel will be organized under the guidance of Parent-Teacher Associations, the skills available will be catalogued, and every household instructed about "Survival Under Atomic Attack." They will be urged to always have on hand the recommended First Aid Kit. In addition, the Warden Service plans one more complete first-aid center in each block. Already an active men's civic club is staging a pilot experiment in setting up an improvised hospital in one of the Atlanta schools. Making use of materials on hand in the community rather than relying on federal hand-outs is the keyword in this planning.

The article ends with a list of specific instructions as to how every Georgia physician can assist in this vital civil defense work. It is in keeping with honored tradition that we again measure up to the leadership responsibilities expected of us.

EDGAR M. DUNSTAN, M.D.

III. OUR TWENTY-FIVE DOLLARS

The Council on Medical Education and Hospitals of the AMA

One of the first acts after the organization of the American Medical Association in Philadelphia in 1847 was the establishment of a Committee on Education. It functioned until 1904 when the Council on Medical Education and Hospitals was formed. The history of the pioneer work of these committees on the improvement in medical education and hospital care in this country is one of the most interesting chapters in the history of organized medicine in America. From the apprentice training in the early days through the primary medical schools of six month duration down to our present high standard of medical education, it reads like a novel of adventure.

In the early days there were no legal restrictions concerning the establishment of a medical school, on the practice of medicine, or on licensing for the practice of medicine. Diploma mills became plentiful and medical schools vied for students. At the beginning of the twentieth century there were about as many medical schools in the United States as in the rest of the world combined.

Up to 1905, medical education in this country was markedly inferior to that in European countries. The requirements for entrance to medical schools were very low, and many schools did not require a high school education. At this time there were 160 medical schools in the United States and one third were in five states. 82 schools were listed as Class A, 46 as Class B, and 32 as Class C. By 1915 the number had dropped to 95 and in 1927 they had been reduced to 80. In 1942 there were 77 schools, and today there are 72 approved by the Council on Medical Education and Hospitals. Yet the number of medical graduates per year has doubled that when there were 160 schools. This

fight for improvement in the standardization of medical schools by the Council was greatly aided by the "Carnegie Study" in 1910, published as the "Flexner Report". This work was done by the Council under Dr. Abraham Flexner's supervision.

Today, the total medical student enrollment is 26,191. This year's graduating class 6,135, the largest in the history of American schools except in 1947 when, under the accelerated program, some medical schools graduated more than one class. The 1951 freshman class will total about 7,400 students. The number of women graduates this year was 468, a decrease for the third year. Women comprise only 5.9% of the total registration. On the other hand, the number of veterans enrolled was 14,528 or 55.4% of all students. The total number of negro students in medical schools for 1950-51 was 658 or 2.5% of all students.

The reduction in medical schools, the higher requirements for admission, and the increased expenditure for medical education has raised the quality of medical care and improved our health. Medical education is never cheap, from the standpoint of the student, the school, or the health of the people. We cannot afford to relax our standard of medical education with the idea that more medical students and less medical training will improve medical care. Health cannot be maintained on a mass production line basis. Individuality is necessary for success in treatment.

From the very beginning of the work on medical schools and hospitals, the Council insisted on a close working connection of the two and insisted that every medical student should have clinical instruction in an organized hospital. Yet as late as 1913 no medical school or state examining board required internship training for graduation or for licensure. However, 70% of the graduates elected to take this training. In 1914 the Council published the first list of approved internship hospitals. At this time, 603 hospitals met the requirements set up by the Council. Today over 28 states and territories require internship training before issuing a license. Yet 99% of all graduates have voluntarily served an internship and the majority have had additional hospital training.

Throughout these developments, the Council set up standards for graduate medical training, post-graduate education, specialty boards, and technical training. The National Board of Medical Examiners was organized in 1915 by the incumbent president of the AMA. Today most of the states and territories recognize this board's examination in lieu of their own examination.

The publishing of data by the J.A.M.A. about all the medical schools and hospitals in this country, has aided in the improvement in the institutions. The Council reports become the guide for standardization by the schools, the hospitals, the profession, and the public. The Federation of State Medical Boards and constituents licensing boards depend on the Council for verification of the cre-

dentials of applicants for licensure. Thus, the approved list of the Council on medical schools, hospitals, and graduates has the force of law although, as a matter of fact, the Council and the AMA have no legal authority over these groups.

The work of the Council on Medical Education and Hospitals covers so many different subjects that this can be only a very brief outline of a very few of its activities. If anyone desires information about hospital and medical schools, such as medical education; approved medical schools for various courses; approved hospitals for residents, fellowships, postgraduate training, and technical training, it can be secured from the Council.

The work of the Council in the past, has been marvelous but their future tasks are just as important and just as difficult. Hospitals and medical schools are facing a serious financial crisis. The dwindling of large fortunes and the reduction of private and corporate income through high taxes has destroyed this source of income for schools and hospitals. The hue and cry for more doctors, and more medical schools has caused some schools to consider lowering of requirements for entrance and for graduation. Do we have too many specialists and are we neglecting the general practitioner? There are also the problems of hospital and physician relationship, hospital standardization, the place of the general practitioner in the hospital, the distribution of interns, and many other problems await a solution. Funds available for medical schools during 1950-51 will total approximately \$109,600,000 which is an increase of more than 36 million dollars in the last four years but, serious financial problems still remain.

The American Medical Education Foundation organized in 1950 started the ball rolling to ease the financial crisis on medical education. Recently it was merged with the National Fund for Medical Education. The former will continue to solicit funds from physicians and other fields of medicine. The latter will concentrate on lay groups, business and industry. The National Foundation has set a goal of \$5,000,000 for 1951 and American Medical Education Foundation has agreed to raise \$1,000,000 of this amount. In the words of Past President Henderson "I urge all American doctors to give maximum support to the continuing drive for private aid to medical education. This new fund-raising consolidation marks only the beginning of the accelerated large scale offensive to show that American methods can provide the nation's medical schools with solvency and freedom."

Hospital standardization is being worked out satisfactorily through a joint committee of all organizations concerned with the AMA having the dominant control. The Reference Committee on Medical Education and Hospitals says, "It appears to us that failure on our part to share in some proportion the overall great responsibility of the proposed agency at this time may bring dis-

credit, possible suspicion, and perhaps other complicating difficulties to our organization."

An advisory committee on Internship has been formed to help in the distribution of interns, especially to non-university hospitals. Many other matters before this Council are being solved as rapidly as possible. They need your support.

EUSTACE A. ALLEN, M.D.

THE AMERICAN MEDICAL WOMEN'S ASSOCIATION

Dr. Bertha Van Hoosen organized the American Medical Women's Association in Chicago in the fall of 1915. Active membership is open to all women "in good professional standing" who have graduated from Class A Medical Schools and who are eligible or belong to a county medical society. Associate membership without dues is offered to interns, residents, and women in their first two years of practice. Junior membership is extended to senior medical students. This latter classification preceded a similar one in the American Medical Association by at least two years. The organization was begun not to accentuate differences between men and women in the profession, but to assist young women and to make more effective by united effort, their contributions to medical science. Present branches of the organization are scattered from coast to coast and many distinguished women enjoy membership.

In 1917, during World War I, Dr. Van Hoosen, as the first president of the organization, appointed a War Service Committee. In a short time this became known as the American Women's Hospitals under which name activity continues. This group sponsors a clinic for Women and Children in Manila and at Levallois-Perret, France. It operates a school of nursing in Greece and partially supports the Polyclinic at Nikaia, Greece. These hospitals are staffed by native women doctors. Support by the American Medical Women's Association not only gives aid to needy women and children in these communities, but it brings prestige and inspiration to the foreign physicians. Until World War II, hospitals were sponsored in China and Japan. At Greenville, South Carolina, a small maternity shelter is also operated under the auspices of the organization.

Young medical women students are assisted with loans. Advice is given on internships and residencies. Women starting to practice are helped to find the most favorable locations and are counseled when they desire it.

This year, for the first time, the Association offers an Award of Merit with \$100.00 in cash to the woman student making the highest four-year average in an American Class A medical school.

The *Journal of the American Medical Women's Association*, under the editorship of Dr. Ada C. Reid, is the voice of the organization. It wins favorable comment here and abroad.

Money is now being raised to erect on the

campus of the Woman's Medical College of Pennsylvania a library. This will not only house the library of the school, but also historical material, and will serve as a memorial to pioneer medical women. Outstanding among these is Dr. Elizabeth Blackwell who graduating in 1849 from Geneva College, in New York, became the first woman physician.

AMEY CHAPPELL, M.D.

THE STUDENT AMERICAN MEDICAL ASSOCIATION

Subsequent to the efforts of this writer in 1944, when Secretary of the Council on Medical Service of the American Medical Association, the Student American Medical Association came to fruition in the latter part of 1950. It had been evident for many years that the Association of Interns and Medical Students did not serve the purposes of such an organization and moreover, was under grave suspicion as a subversive organization. It was quite evident at the time, 1944, when he attempted to have such an organization formed, that an association sponsored by the American Medical Association would be the best answer to the question. A part of his efforts at that time consisted of writing a tentative Constitution and By-laws for the proposed American Medical Students Association. Students from the University of Georgia School of Medicine were invited by the Council on Medical Service of the American Medical Association to come to Chicago and present the plans for the organization. This was done, but for some reason the matter lay dormant for six years.

It is most heartening now to know that the Student American Medical Association is a going concern and that in the near future there will be chapters in all the approved medical colleges in this country. The Medical College of Georgia enjoys the distinction of being the first medical school to have one-hundred percent membership with all dues paid.

The possibilities for good in such an organization are limitless. With a suitable publication, the tenets of organized medicine can be made known to the young physicians of the future and before the time for location to practice, such young men and women will know the background of organized medicine and will be prepared to take up the duties that go with the privilege of being a member of the medical fraternity.

The authority of this association has been placed in an Executive Council which consists of three officers of the Association, three executive council members elected by the student House of Delegates, and three senior councilors appointed by the Board of Trustees of the American Medical Association. As a recognition no doubt, of the

services of this writer in his earlier attempt to start this organization, he was appointed one of the three senior councilors.

Mr. Leo Brown, formerly Executive Secretary by appointment of the Trustees, has been succeeded by Mr. Russell F. Staudacher. Mr. Staudacher is a thirty-six year old Michigander and was formerly Associate Public Relations Counsel for the Michigan State Medical Society. He assumed his duties July 1, 1951 after Mr. Leo Brown, in March, had been promoted to become Public Relations Director of the American Medical Association. Mr. Staudacher brings wide experience in public relations, organizational work and writing to his new position, where his duties are combined with the dual and associated position of Executive Secretary of the American Medical Education Foundation, the vehicle set up to encourage financial support of medical schools.

A principal item on the agenda of the Student American Medical Association is to achieve chapter membership in all approved medical schools by January, 1952. The present indication is that this hope has every expectation of fulfillment.

Manuscripts and articles are now requested for the proposed S.A.M.A. Journal which will begin publication, January, 1952. Preliminary replies from prospective advertisers have been most encouraging and present plans look forward to a Journal which will be published during all the months of the school year. To quote from the third and last issue of "News Vox" (a temporary publication of the Association):

"The Student American Medical Association will begin publication of a 72-page (or larger) Journal, to be published monthly except during July, August and September, such publication to start with the January 1952 issue. Advertising in the Student A.M.A. Journal will be restricted to the manufacturers of products accepted by the various Councils of the American Medical Association."

All those who have been active in the organization of this association and all of the students who were appointed at the first convention as members of the Executive Council, and particularly the President, Mr. Warren Mullen, are deserving of the thanks and appreciation of all members of organized medicine. It is hoped that the parent association will continue its support until this organization reaches the stage where it will no longer require a subsidy. Every medical student should belong to this association throughout the four years of his medical course, and he will be richer for it in experience and in accumulation of knowledge during his intern and resident days and later when he is a practitioner of his profession.

G. LOMBARD KELLY, M.D.

Scientific Articles

CULDOSCOPY, A VERSATILE DIAGNOSTIC AID

JOHN H. RIDLEY, M.D., Atlanta

CULDOSCOPY is one of the more recent forms of endoscopy which has proven itself to be valuable, particularly in pelvic surgery and pelvic differential diagnosis. The immediate predecessor to this technic was that of peritoneoscopy used sporadically and fairly successfully for intra-abdominal visualization since the turn of the twentieth century. However, for pelvic inspection the peritoneoscope has definite and accepted limitations. The chief difference between the peritoneoscope and the culdoscope is that the former is used through an incision in the anterior abdominal wall, while the latter is used in pelvic visualization by a trocar puncture into the cul-de-sac through the posterior vaginal fornix. To use the peritoneoscope successfully it is necessary to create a positive intra-abdominal pressure by pumping air or some readily absorbable gas in through the incision. However, the culdoscope, used necessarily in the knee chest position, takes advantage of the creation of a negative intra-abdominal pressure which allows the abdomen to distend passively as the cul-de-sac puncture is made.

Dr. Albert Decker of New York City first described the culdoscope in 1944¹. Since that time the use of the instrument has gained in popularity and by now has become fairly thoroughly evaluated as a diagnostic aid.

Apparatus: The culdoscope and its few accessories are pictured in Figure 1. The instrument itself is a straight endoscope measuring about 25 cm. in length, bearing its built-in illumination and a right angled lens. The image visualized is true and has slight magnification when the object seen is less than one inch from the objective lens. A small bead on the bakelite eye piece facilitates in orientation by designating the direction in which the right angle lens is viewing².

The trocar is a simple triangular pointed

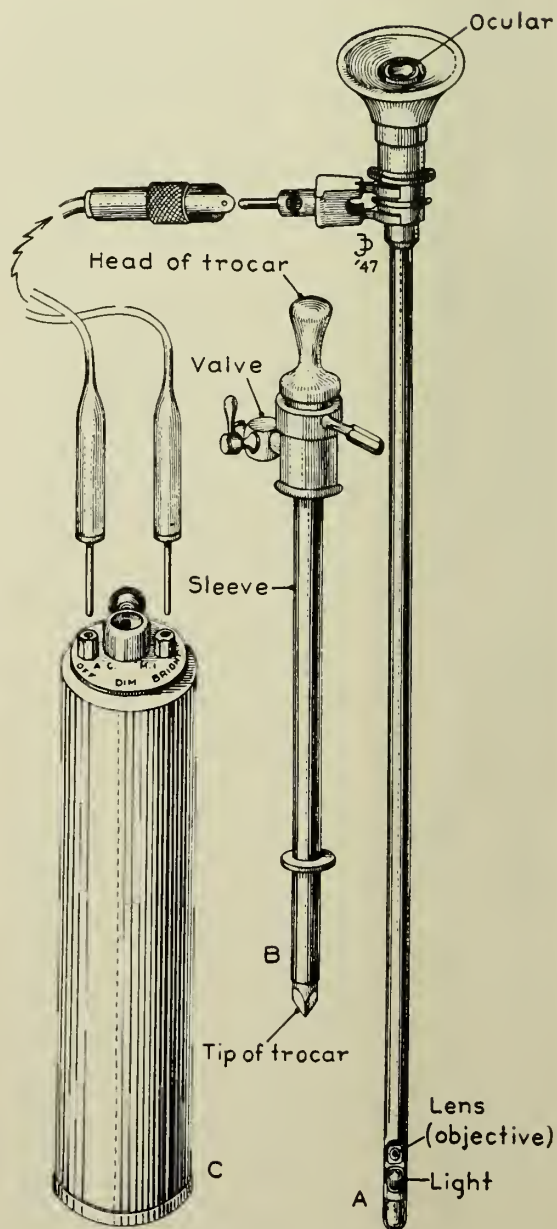


Fig. 1. Culdoscope. Description of instrument is found in text. (Am. J. Obst. & Gynec. 55:2, 1948).

instrument similar to that used in simple paracentesis. It projects slightly beyond the cannula when in locked position. The cannula, as will be seen, has a flange on the tube about 3 cm. above the tip to prevent insertion to too great a depth. Illumination is provided by either a dry cell battery or a small transformer and rheostat. The stop-cock on the tip of the cannula allows the use of CO₂ or some other quickly absorbable gas if the operator does not wish to allow the abdomen to be distended with air. In this series of cases reported, air has been used practically routinely without ill effects except occasional shoulder pain due to slow absorption of the intra-abdominal air.

Procedure: The patient is anesthetized, catheterized and examined in the dorso-lithotomy position. Examination after anesthesia is important to thoroughly evaluate the cul-de-sac to see if there is any physical contraindication to the cul-de-sac puncture, such as an adherent mass or extensive adhesions. This examination under anesthesia is important also because additional pathology may be found, or such pathology found to contraindicate culdoscopy and indicate immediate laparotomy.

A vaginal clean-up is used as for any transvaginal abdominal procedure. The patient is now turned to knee-chest position and the cervix exposed. The posterior vaginal retractor not only exposes the cul-de-sac well but also protects the operative field from soilage from the perianal area. The posterior lip of the cervix is grasped and brought down gently by traction. The trocar and cannula are thrust into the cul-de-sac through a small anatomic depression between the insertion of the uterosacral ligaments. This instrument is directed downward about 45° angle to protect the rectum and parallel the posterior surface of the uterus. Figure 2 shows the site of puncture in the posterior fornix. When the trocar is removed there is an audible inrush of air, usually about 1800 cc., signifying that a successful intra-abdominal puncture has been made. If this is not accomplished at the first attempt it is best to withdraw the trocar and cannula and make another attempt after examination for the cause of the first error³. The culdoscope itself is now put into position and the pelvic viscera visualized (Figure 3). More extensive visualization of the pelvic organs may be accomplished by

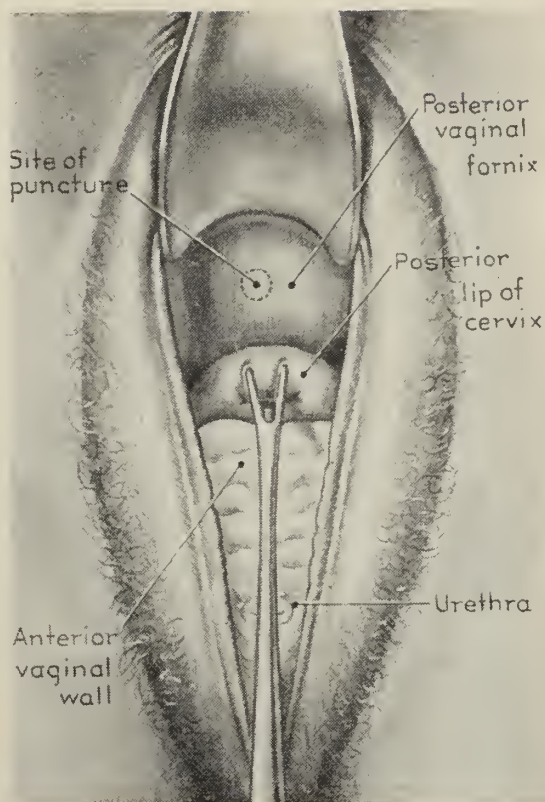


Fig. 2. Site of puncture. (Am. J. Obst. & Gynec. 55:2, 1948).

manipulation of the cervix, and by suprapubic pressure by either an assistant or by the operator himself.

The anesthetic agent of choice is sodium pentothal 2½ per cent solution given in a dorsal vein of the hand. This site of injection

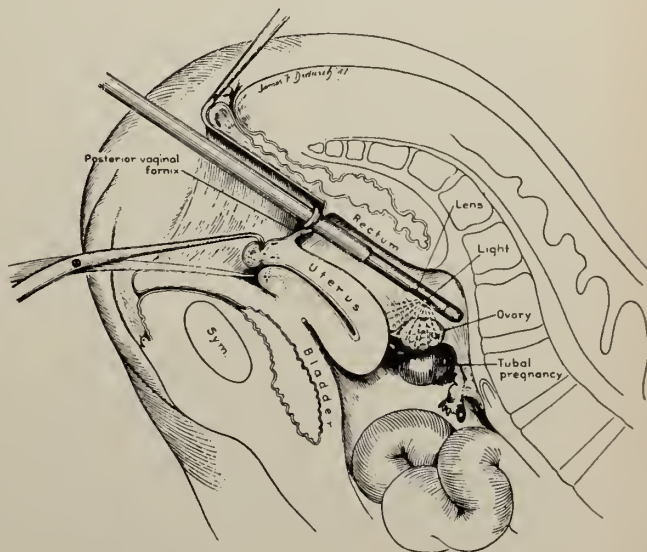


Fig. 3. Instrument in place. (Am. J. Obst. & Gynec. 55:2, 1948).

facilitates continuation of anesthesia when the patient is turned to the knee-chest position.

In four of the reported cases local anesthesia was used with only slight variation of the operating technic. A nonirritating vaginal clean-up is used and 2 per cent novocaine was used to infiltrate both superficially and deeply in the posterior fornix of the vagina and in the extraperitoneal area of the cul-de-sac. This is really the type of anesthesia of choice, but it is limited in its use because of occasional poor patient cooperation and also pain on traction of the uterus.

One case was performed under spinal anesthesia which likewise proved successful but not so desirable because of the possibility of variation of anesthetic level in the knee-chest position.

When the culdoscopic examination is completed the instrument is withdrawn but before the cannula is withdrawn positive pressure is placed on the abdomen to express as much of the air as possible. This can be done so completely as a rule that the patient suffers no postoperative abdominal discomfort. It is never necessary to suture the small puncture site in the cul-de-sac. There has not been encountered any instance of postoperative hemorrhage or persistent patency of the opening.

Indications: The most common indication for culdoscopy encountered in this series has been for proving or disproving the provisional diagnosis of ectopic gestation. Every gynecologist at one time or another has been confused by the differential diagnosis of the existence of ectopic pregnancy, and the final diagnosis is made only after direct visualization of the pelvic viscera. This necessitates at times what should be called a diagnostic laparotomy, which has frequently been avoided by use of the culdoscope. On the other hand, the diagnosis of ectopic pregnancy may be established by culdoscopy where otherwise delay in diagnosis might be disastrous.

It is true that the great majority, probably 85 per cent, of ectopic pregnancies can be diagnosed on history and physical examination alone, a few even being the classical textbook pictures. However, there is an appreciable number that defies all efforts of diagnosis short of actual visualization of the pelvic viscera. Culdoscopy has appreciably raised the percentage of cases having an accurate diagnosis preoperatively and on the

TABLE 1

Culdoscopic Examinations, October 1948-February 1951	38
<i>Indications:</i>	
Suspected ectopic pregnancy	21
Ectopic pregnancy found	8
Ectopic pregnancy ruled out	13
Ovarian cysts of borderline size	5
Follicular cysts	4
Solid tumor (dermoid)	1
Suspected tuberculous peritonitis	1
Pelvic tumor of unknown type (proven to be of sigmoid origin)	1
Pelvic examination for infertility study	6
Negative findings	3
Early endometriosis	1
Chronic P. I. D.	2
Postmenopausal bleeding (obese—? estrogen effect)	1
Endometriosis vs P. I. D.	1
Diff. app. from salpingitis	1
Precocious Puberty (aged 9)	1

other hand has often satisfactorily ruled out the questionable case. In this series of cases a wide variety of pathology has been encountered, among which are bleeding corpora lutea, early intra-uterine pregnancy with corpus luteum formation and ovarian enlargement, chronic pelvic inflammatory disease with unilateral inflammatory cystic masses, and a case of a pedunculated fibroid. Table 1 illustrates the number of culdoscopic examinations performed in a twenty-seven month period ending February 1951. These cases are taken both from my private practice and from the ward cases at the Grady Memorial Hospital in Atlanta. The total number is 38. Breakdown of this number shows that 21 of these procedures were performed in cases suspected of being ectopic pregnancies. This comprises 57 per cent of the total number performed. In eight of these 21 cases ectopic pregnancy was definitely found and in 13 cases ectopic pregnancy was ruled out, demonstrating the value of the culdoscope in avoiding a major surgical procedure for diagnostic purposes.

Ovarian enlargements of borderline size were inspected in five cases. In four of these cases the enlargements were found to be due to follicular cysts, obviating the need for immediate surgery because so frequently these cysts shrink in size under observation. The other ovarian tumor was thought to be solid in nature and the appearance on culdoscopy suggested the presence of a dermoid

cyst. This was substantiated by laparotomy. The term "borderline" is used as descriptive of those ovarian enlargements of about 3 to 4 cm. in size, or about the size of a golf ball, which is within normal limits of functional ovarian enlargement⁵.

The case of suspected tuberculous peritonitis was proven by culdoscopy in a thirteen year old colored child who was placed on the prescribed course of dihydrostreptomycin after the diagnosis of tuberculosis had been definitely made.

The culdoscope has proven to be of value in completion of infertility studies. Six such cases are listed in Table 1. Findings were completely negative on three. Early endometriosis thus far unsuspected was found in one, and a chronic pelvic inflammatory disease was found in two. The point of tubal obstruction was demonstrated in one case by the injection of methylene blue through a cannula in the cervix.

The other cases listed are of a miscellaneous nature. However, in the case of the postmenopausal bleeding the patient was very obese and showed a questionable estrogen effect of her vaginal mucosa. Culdoscopy showed a completely normal pelvis, ruling out any gross pathology of the ovaries such as a granulosa cell tumor. Follow-up of this patient substantiated the findings.

There were no accidents and no postoperative morbidity in this series. All of those patients who did not undergo immediate laparotomy following culdoscopy were allowed to go home the following day. Accidents with the culdoscope are few and far between. There have been isolated reports of entry to the rectum. This operator had such a case in 1947 when the rectum was inadvertently entered in a case of chronic pelvic inflammatory disease. The entry was extraperitoneal and healed per primam. There was no postoperative morbidity in this case. To my knowledge there are no known mortalities due to culdoscopy.

It is my belief that the culdoscope practically replaces the procedure of simple posterior colpotomy. The findings on colpotomy alone are often misleading. When blood is encountered in the cul-de-sac it may be hemorrhage from the colpotomy itself or it may be hemorrhage from some other source exclusive of an ectopic pregnancy—a

notable example being bleeding from a corpus luteum. Therefore the simple existence of a hemoperitoneum does not necessarily indicate immediate laparotomy. The cause of the bleeding can often be seen by the culdoscope whereas it cannot be visualized through a colpotomy opening. In fact, satisfactory visualization of the pelvic viscera is most difficult and sometimes impossible by colpotomy, first because the patient is in a dorsal lithotomy position and second because there is frequently inadequate vaginal relaxation to permit desired manipulation and proper lighting. Likewise the omentum and large or small bowel may be prolapsed if not adherent in the cul-de-sac, making visualization difficult.

Culdoscopy cannot be compared with a laparotomy in regard to the magnitude of the procedure. In some clinics culdoscopy has been used as an office procedure, although the author does not advocate this. However, culdoscopy permits the patient to leave the hospital usually on the following postoperative day, whereas laparotomy requires much longer hospitalization and greater patient risk even without complications.

Another valuable use of the culdoscope is in simple inspection of the urinary bladder. This is likewise done with the patient in knee-chest position, as an office procedure. Information may be gained by this simple procedure which might obviate the necessity of more detailed urinary tract work-up⁴.

In summary it may be said that culdoscopy is one of the newer technics of endoscopy which has become a versatile diagnostic aid in cases requiring differential pelvic diagnosis. This procedure spares many patients major surgical procedures which otherwise would be done for diagnostic reasons only. Culdoscopy is a safe procedure, easily done, and—in the great majority of cases—completely satisfactory in giving the information sought.

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THE INCIDENCE OF CARCINOMA IN NODULAR THYROIDS IN SOUTHWEST GEORGIA

CHARLES H. WATT, M.D., and JOHN C. FOUSHEE, M.D., Thomasville

RATHER numerous writings on the subject of carcinoma of the thyroid during recent years have done much to focus attention on this condition, and particularly upon that phase of the disease relating to the incidence of carcinoma in the non-toxic nodular goiter. That this is as it should be, is established by the amazingly high incidence of cancer which has been found to occur in this type of goiter. However, it was because of this rather high percentage and the doubt in our minds that carcinoma occurred with such frequency in our part of the country that led us to review the cases of goiter seen at the Archbold Memorial Hospital in Thomasville, Georgia, over the twenty-five year period from 1925 to 1950.

However, before presenting the findings in our relatively small series of cases, let us consider briefly the subject of malignancy of the thyroid and of the thyroid nodule. Why, for example, has the incidence of carcinoma of the thyroid increased during the past ten years? Pemberton¹ attributes the former lack of diagnosis and an increasing incidence to recognition of early forms by pathologists in recent years. Even now pathologists are not in complete agreement. Many feel that blood vessel invasion of itself is not sufficient for a diagnosis of malignancy and demand in addition either evidence of invasion of the capsule or metastases. In this respect some workers at the Mayo Clinic¹ made a study which may be of aid in the future. They found definite evidence that in the cells of the malignant adenoma the nucleoli occupy a greater area of the nuclei than do the nucleoli of corresponding benign tissue. Further evidence of confusion is found in the rather numerous classifications which have been suggested and used by various clinics. These vary from the relatively elaborate one by Dr. Allen Graham down to that of Dr. George Crile, Jr., which is perhaps the simplest of all. Crile² has the following to say: "From a clinical point of view carcinomas of the thyroid can be divided into two main groups,

the papillary and non-papillary. Papillary carcinomas generally behave as lymphangio-invasive tumors and metastasize to lymph nodes, whereas non-papillary carcinomas are hemangio-invasive and metastasize chiefly through the blood stream. The great difference in the clinical behavior and prognosis of these two groups can be explained by their respective tendencies to invade lymphatics and blood vessels. These papillary tumors occur frequently in children and young adults, whereas non-papillary tumors follow more closely the general age distribution of most other carcinomas.

Papillary tumors, also, carry a much more favorable prognosis than the non-papillary variety. Even when there is extensive metastases to regional lymph nodes, cures usually are affected by the removal of the tumor and metastatic nodules, whereas when non-papillary tumors metastasize to lymph nodes the prognosis is hopeless."

The slow growth of some thyroid malignancies almost sets them apart from carcinoma of other organs. There is the patient, for example, with known carcinoma who refused operation, but who was subsequently followed for some twenty-five years during which time he slowly developed more and more metastatic nodules in the neck². Similarly, there is the case reported by Ward³, operated on at the age of nine for cancer of the thyroid. A chest plate at that time showed it to be riddled with metastases. It was not until 13 years later, however, at the age of 22 that he developed local recurrence and laryngeal paralysis.

This slow growth and the advantages offered by early surgery are reflected in follow-up figures. About what other type of malignancy can a statement like the following from the Mayo Clinic be made? "The percentages of patients with malignant tumor of the thyroid gland who have lived 3, 5 and 10 years or more after treatment are 77, 70 and 58 per cent respectively¹."

The high incidence of cancer of the thyroid in children has been noted by several observers. Kennedy¹⁸ (quoted from four) reports an incidence of 19.3 per cent in 62

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children with goiter. Ward³ reported an incidence of 40 per cent in 10 children under the age of 14 with non-toxic nodular goiters and Coffey⁵ noted an incidence of 55.5 per cent in nine children under 13 years of age.

Less generally known perhaps is the relatively high incidence of malignancy in male patients. Cole⁴ noted that the danger of malignancy in a nodule in the gland of a male was about three times as great as in females. Ward³ found the incidence of carcinoma in men with nodular growths to be 14 per cent or one out of each seven coming to surgery.

The high incidence of carcinoma in non-toxic nodular goiter, particularly those with single nodules in which the incidence has been reported as high as 15.6 per cent, Ward³ to 24.4 per cent Cole⁴ and the necessity for operating on these people early before the diagnosis becomes obvious has been emphasized. Just how many of these lesions cannot be diagnosed preoperatively is brought out in reviews like those of Hinton and Lord², Cole⁴, Pemberton¹ and Coffey⁵.

Hinton and Lord studying a five year group of operative cases found that after eliminating all cases diagnosed carcinoma preoperatively they had left 184 cases of clinically benign nodular goiter which showed an incidence of 7.6 per cent cancer on pathologic examination. Pemberton¹ in a review of the clinical diagnosis of the surgical cases found that in 60 per cent the presence of a malignant tumor was not suspected but found by the surgeon or pathologist. Furthermore, of this group, 8 per cent showed an advanced inoperable condition indicating that there may be no clinical findings on which the diagnosis of malignant tumor can be based. More recently Coffey⁵ has reported unsuspected carcinoma found in 11.5 per cent of a group of cases from the Georgetown University Medical Center. When one considers these figures in the light of the followup findings of Ward³ to the effect that of those with lesions diagnosed preoperatively only 20 per cent were living after five years, of those diagnosed at operation 40 per cent were living after five years,

Table 1
Comparison of Incidence of Carcinoma in Nodular Goiter in
Various Parts of the Country

	No. Patients with nodular goiter (toxic and non-toxic)	Carcinoma % in nodular goiter (toxic and non-toxic)	No. patients with nodular non- toxic goiter	% Carcinoma in nodular non-toxic goiter	Carcinoma % in solitary non-toxic nodular goiter
Brenizer and McKnight ⁴ Charlotte, N. C. 1940	2324	4			
Horn and associates Philadelphia, Pa. 1947	1135	6.3	637	9.8	
Crile Cleveland 2, Ohio 1948	537	5.6	274	10.9	24.5
Ward San Francisco 3 1947	3539	4.8			15.6
Cole and associates ⁴ Chicago 1948	663	8.0	285	17.1	24.4
Canipelli Atlanta ¹⁶ 1949	102		73	5.4	11.4
Watt and Foushee Thomasville 1951	272		214	1.7	2.5

whereas of those diagnosed only by the pathologist 80 per cent were living after five years, the need for prophylactic removal becomes rather urgent.

Analysis of Cases

The data forming the basis of this report were obtained from a study of the clinical records of 379 patients with a diagnosis indicative of an enlarged thyroid admitted to the Archbold Memorial Hospital from 1925 to 1950.

Of 379 patients, 272 had a clinical diagnosis of nodular goiter, 214 were non-toxic and 124 were classified as having more or less discrete nodules. 177 of the 214 patients were operated upon and of those with discrete non-toxic nodules, 117 were operated upon.

There were three patients with carcinoma with a lesion that obviously was too far advanced to be benefited by surgery. In addition to these, there were three other patients with carcinoma whose diagnosis was not suspected preoperatively, thus making a total of six carcinomas or an incidence of 1.7 per cent for the entire group. All three undiagnosed carcinomas occurred in patients with discrete non-toxic nodular goiters, giving an incidence of 2.5 per cent for the group of non-toxic discrete nodular goiters which came to operation. Of the three, one was diagnosed at operation and the other two by the pathologist.

Of three patients not suspected of having carcinoma before operation, one was a 48 year old white male operated upon in 1944 and follow up studies seven years after operation showed no evidence of recurrence. The second patient was a 36 year old white male operated on in 1945. Five year follow up reveals no evidence of recurrence. The third patient was an 18 year old girl operated upon in 1936. Fifteen year follow up reveals that an asymptomatic recurrence was first noted by the patient about a year ago. This has enlarged slightly since first noted. Examination revealed a small, hard, somewhat fixed nodule on the left measuring approximately $2\frac{1}{2}$ cm. in diameter and two small adjacent fixed nodules on the right, each measuring about $1\frac{1}{2}$ cm. in diameter. This patient is now receiving x-ray therapy.

Comment

From this data we find that two of the patients were males. Of the entire group of patients studied, 35 were males and of these, twelve had discrete nodules. Of the twelve, nine were operated on and two were found to have carcinoma, an incidence of 22.2 per cent. This high incidence of carcinoma in males with single nodules compares with the findings of others as has been previously mentioned.

The incidence of carcinoma in 1.7 per cent of patients with non-toxic nodular goiter, or 2.5 per cent in discrete nodular goiters, is lower than any previously reported. This fact had been suspected before this study was made. In comparing this figure with that of Crile², we might explain the difference on the basis of the fact that Dr. Crile does not advocate operating on any patients with asymptomatic nodules except those of certain consistency, whereas we have operated on all patients with nodular goiters, especially those with discrete nodules, no matter what the consistency. This would, of course, materially increase the percentage in his series. Such an explanation, however, does not hold true when we compare our findings with those of Cole⁴ who found an incidence of 24.4 per cent of carcinoma in discrete nodular goiter in a series of patients studied between 1944 and 1948 at the Illinois Research Hospital. At this time they had recommended operation on every patient with non-toxic nodular goiter seen and stated that practically all patients accepted their advice. There is the possibility, of course, that this group of patients may have been more or less screened by the referring physicians, thus increasing the percentage of carcinomas.

Another explanation might lie in the fact that, as is well known, the incidence of goiter and cancer of the thyroid is less along the Atlantic Seaboard than in goiter belts⁴. For instance, a comparison of our figures with those of Johns Hopkins and the Massachusetts General Hospital and Boston City Hospital shows:

(See Table 2, opposite)

The percentages are essentially the same. A recent report from the Lahey Clinic¹⁷ shows an incidence of 10.4 per cent in patients with discrete adenomas. However, since patients come to this clinic from all parts of the country for surgery, these figures cannot be considered as representative

Table 2

Hospital	No. Cases	Goiters	%	Carcinoma	% Carcinoma
Johns Hopkins Boston City Mass. General	544,918	3221	.59	64	1.99
Illinois Research Hospital	68,576		1.70		
Archbold Memorial Hospital	73,138	379	.518	6	1.58

of the Atlantic seaboard. Even along the Atlantic seaboard, the lowest reported figures are the 4 per cent found by Brenizer and McKnight of Charlotte, North Carolina, in 1940. Finally, the low incidence in our series may be questioned on the grounds that the specimens were examined by several pathologists over a period of years and some pathologists have only recently come to recognize the early forms. However, since none of these cases have returned with recurrences, it is assumed that there was none.

This paper is not presented for the purpose of attempting to repudiate any former reports but rather to support the advice of others, despite our small series and apparent low incidence of carcinoma. Even though this was noted to be 2.5 per cent, it is higher than our operative mortality, for there have been no operative deaths in this series.

Having made a rather thorough study of the literature on this subject and having reviewed our own small series, we are convinced that all discrete nodules of the thyroid should be removed. To quote Crile², "Not that a discrete adenoma may become malignant, but rather that it is already malignant".

Mental Clinic Asked for Atlanta

Establishment of a 150-bed "out-patient" mental clinic in Atlanta, supported by state funds, is advocated by Fulton County Representative Luther Alverson to improve care of mental cases in this state.

Alverson made his suggestion as he and State Welfare Director Alan Kemper indorsed recommendations of the Medical Association of Georgia for eliminating the "prison stigma" from mental cases.

THE JOURNAL of the State Medical Associa-

Summary

A brief review of some of the interesting facts about carcinoma of the thyroid have been presented.

A series of cases from southwest Georgia and northern Florida has been reviewed in which the incidence of carcinoma was found to be less than any previously reported.

An attempt to explain the discrepancy between our findings and those of other non-endemic areas has been made.

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tion editorially urged the General Assembly to provide for voluntary admission into the Milledgeville State Hospital, instead of treating mental cases as criminals by issuing warrants and trying them in courts.

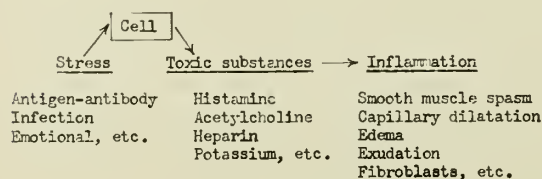
The Medical JOURNAL suggested that in addition to the main screening center at Milledgeville the state should subsidize psychiatry departments in general hospitals in the more heavily populated counties to act as screening centers.—M. L. St. John in the *Atlanta Constitution*.

THE ADRENAL CORTEX AND ALLERGIC REACTIONS

WILLIAM F. FRIEDEWALD, M.D., and CLARENCE L. LAWS, M.D., Atlanta

BENEFICIAL effects following the use of ACTH and cortisone have been described in various types of allergic reactions. Recent studies have clarified to a large extent the mechanism of action and the clinical indications and limitations of these substances in the management of patients with allergic manifestations.

For purposes of discussion the chain of events involved in allergic reactions can be represented diagrammatically as follows:



A number of experimental studies have been reported which deal with the effect of ACTH or cortisone on the various components of this reaction. Although there are conflicting reports regarding the effect of ACTH and cortisone on antibody formation, it seems clear that interference with the union of antigen and antibody is not an important factor in the mechanism of the action of these hormones. It is possible that the euphorogenic action of these substances plays a role in those stress situations in which emotional factors are important. It has been shown that these substances do not influence the release of histamine, prevent anaphylactic reactions, inhibit the Arthus reaction, or cause a rise in circulating antibody levels in experimental animals despite a decrease in the number of circulating lymphocytes. Cortisone does not influence passively induced skin hypersensitivity in man and does not alter scratch and intradermal tests on ragweed sensitive patients. Guinea pigs with active tuberculosis treated with ACTH or cortisone develop definite tuberculin skin reactions, although the reaction appears less marked in the treated animals than in the controls¹. ACTH prevents

the hemorrhagic necrosis of the Shwartzman reaction, although it fails to prevent the elicitation of the state of reactivity. It has demonstrated that the arterial lesions produced in rabbits by injections of horse serum can be suppressed by ACTH or cortisone. Despite the inhibitory effect of the hormones on the development of the systemic lesions of anaphylactic hypersensitivity in the rabbits, no significant change in the skin reaction or serum precipitins occurred².

The available evidence indicates that neither ACTH or cortisone interfere specifically or primarily with the immune mechanisms of allergic reactions but decrease the associated inflammatory response. This effect has been clearly shown in histologic studies of various lesions and the delay in the healing of wounds and fractures, with a marked depression of granulation tissue, leucocytes, fibroblasts and proliferating blood vessels. Thus, the beneficial effects of these substances in hypersensitive states, including the collagen diseases, appear to be due to a generalized depression of the inflammatory reactivity of the tissues.

ACTH and cortisone have been most helpful in the management of patients with status asthmaticus, acute urticaria, allergic reactions involving the eye, and atopic dermatitis refractory to other forms of treatment. Although the results are often dramatic in these conditions, a number of patients are encountered in which no beneficial effects can be attributed to the administration of these substances. The reason for these failures is not entirely clear at the present time. More information is needed regarding the functional status of the adrenal cortex in patients with allergic diseases. The eosinophil response to test doses of ACTH or cortisone has not proven to be a reliable indicator of adrenal cortical function. Limited studies have indicated that corticoid excretion is lower in chronic asthmatics with infection than in the younger group with positive skin tests to extrinsic allergens³. It has not been possible, however, to correlate clinical improvement with the excretion of corticoids.

It should be emphasized that ACTH and cortisone do not alter the basic allergic state

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and in reality appear to provide only symptomatic relief. There is no justification for the routine use of these substances in the treatment of allergic reactions. Most of the reactions can be successfully treated by other procedures of established value and safety. It is necessary, therefore, to carefully consider the indications for the administration of ACTH or cortisone in a given patient, particularly since they affect many important metabolic and physiologic processes in the body and undesirable effects may be produced. It is generally recommended that all patients under treatment receive a low sodium (200 mg.) diet and a high potassium intake. ACTH and cortisone should not be given to diabetic individuals. Further considerations include the possible harmful effects of ACTH and cortisone in patients with infections, particularly tuberculosis⁴,

and the antigenic nature of these substances occasionally giving rise to hypersensitivity reactions through repeated usage.

There is no doubt that ACTH and cortisone are important additions to the long list of drugs used in the treatment of allergic reactions. The successful management of these patients, however, remains not so much a matter of drugs and the mere treatment of symptoms, but a real understanding of the patient, his physical and emotional makeup as well as his allergies, and the application of this knowledge to the control of his disease.

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CORTISONE AND THE ADRENO-GENITAL SYNDROME

PETER L. SCARDINO, M.D., AND CHARLES L. PRINCE, M.D., Savannah

STIMULATED initially by the early work of the adrenal physiologists^{1,2}, and encouraged by the recent reports of Wilkins and his co-workers³, we wish to report our results on the use of cortisone to suppress excessive androgen production in congenital adrenal hyperplasia.

A discussion before this group of the use of cortisone to suppress excessive androgen secretion in congenital adrenal hyperplasia does not require a review of the literature regarding the adreno-genital syndrome.

The most common adrenal disorder encountered in childhood is that of female pseudohermaphroditism. If the disorder has its onset as a congenital lesion of adrenal hyperplasia, the resulting abnormality is that of female pseudohermaphroditism. If the lesion occurs after the intrauterine differentiation of the sex organs is complete, female virilization occurs.

In the female pseudohermaphrodite there are ovaries, and the Mullerian duct system undergoes normal female development to

form Fallopian tubes, uterus, and vagina. The Wolffian ducts disappear. However, the genital duct continues to open into the urethra and forms a persistent urogenital sinus as in the male. In the normal female the urogenital sinus develops into a separate urethra and vagina which opens into the vulvae. This is the characteristic abnormality found in the female pseudohermaphrodite and was the condition encountered in the case to be presented.

Descriptively, the clitoris is found to be hypertrophied resembling somewhat the hypospadiac penis but is composed only of corpora cavernosa, and lacks a corpus spongiosum. The clitoris is held ventrally in chordee by fibrous cords. Usually the labia majora are hypertrophied while the minora are undeveloped or represented only by fibrous cords. Between the labia there is a shallow, trough-like vulvar depression covered with mucous membrane. Into this opens the urogenital sinus, usually with a small orifice resembling the meatus urethrae. The communication with the vagina can usually be demonstrated by vaginogram or visualized with the urethroscope⁴.

These individuals show evidence of in-

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creased secretion of androgen which is manifested by abnormal somatic growth, excessive muscular development and premature epiphysial ossification. Pubic hair appears by the age of two to five years and is shortly followed by axillary hair. Acne develops early. Hypertrophy of the clitoris increases and there may be almost constant erections. The voice deepens. The secretion of 17-ketosteroids is always increased in relation to the patient's age. The child's general appearance may be quite feminine in early childhood. However, at the age of adolescence, breast development and menstruation fail to occur. Epiphysial fusion occurs early. The patients often become short, stocky, very muscular individuals with coarse dark hair on the thighs, legs, abdomen and face.

It has been demonstrated that the adrenal gland produces several hormones of which the androgen-like or "N" hormone possesses properties similar to testosterone². Also produced is the "S" hormone which is opposite in action to the "N" hormone. It has been postulated that administration of the "S" hormone or cortisone might neutralize the excessive "N" hormone which was thought to be responsible for the major clinical manifestations in congenital adrenal hyperplasia⁵. These theories were investigated by other workers including Wilkins and Lewis and their colleagues. They attempted unsuccessfully to suppress the secretion of 17-ketosteroids in patients with adreno-genital hyperplasia by the use of other steroids such as 17-ethyl testosterone, 17-vinyl testosterone and others which have a chemical structure similar to that of androgens but which possess relatively little androgenic activity⁶.

With the advent of cortisone, it occurred to many workers that herein might lie the answer to the treatment of congenital adrenal hyperplasia. As soon as cortisone (11-dehydro-17-hydroxycorticosterone) became available, it was administered to these patients. It was the hope that such a hormone, which is essential for normal metabolism, when given adequately might suppress the endogenous activity of the adrenals including hypersecretion of androgen. This is all in keeping with the earlier suggestions of Wells and Kendal¹ (*vide supra*). Should such a theory prove practicable, it would obviate the difficult conversion of the female pseudohermaphrodite to a functionally sterile male by the urological manipulations de-

veloped by Young⁷. This required conversion of the hypertrophied clitoris to a functioning penis with the plastic conversion of the remnants of the urethra and urogenital sinus into a urinary duct of some continuity. At best this was a compromise and only occasionally proved satisfactory. It was with the above knowledge and experience that the case to be presented was managed.

Case Report: The patient (L. R. J.), a female pseudohermaphrodite seven years of age, came under our observation on August 19, 1949. The child was noted at birth to have peculiar external genitalia but no changes were noted in their size until the age of two months when the mother noted that the phallus had grown larger. This clitoral enlargement continued unabated. The parent noted the development of pubic hair and abnormal muscular development of the trunk and extremities at the age of four. The voice was deep. Acne developed on the face at age five and persisted. There was no axillary hair development. The examination revealed a shy, apathetic, unhappy child who was asocial and who refused to cooperate. She had been living on a farm with adults because of her antagonistic attitude toward other children. She was seven years of age with an eleven year bone age. There was facial acne. The hair was coarse; the voice was deep; the trunk and extremities showed advanced muscular development. The remainder of the examination revealed a luxuriant growth of pubic hair. The clitoris was hypertrophied with ventral cords previously described as occurring in the typical female pseudohermaphrodite. The labia majora were well developed but only cords represented the labia minora. The urogenital sinus accepted the examining finger with difficulty.

Cystoscopic examination revealed a urogenital sinus. The vagina visualized with the urethroscope was in direct communication with the urethra. (Intravenous urography was normal).

On August 26, 1949 exploratory laparotomy revealed an infantile uterus with cystic ovaries, normal appearing Fallopian tubes and grossly normal glands. Biopsies were taken from both adrenals and both ovaries. Pathological report: Bilateral adrenal tissue within normal limits except lipidoid material in the outer portion of the zona reticulata. There was bilateral ovarian stroma without primordial follicles. Histologically one could not recognize adrenal hyperplasia or other abnormality of the ovarian stroma except for the absence of primordial follicles.

Postoperatively the patient did well but remained lethargic, apathetic and asocial.

In view of the recent stimulating work on adrenal physiology, it occurred to the authors in September 1949 that soon cortisone would be available to the practitioner and that this female

pseudohermaphrodite should not be converted anatomically to a male. Consequently, contrary to previous practice, a clitorrectomy was performed on September 7, 1949. There was little change in the patient's behavior pattern following this procedure. She was not seen again until September 1950 when she returned for consultation. Through the efforts of the Welfare authorities in Savannah, a liberal supply of cortisone was made available.

After a control period of seven days, during which the urinary 17-ketosteroids were measured daily, treatment was begun. She was given cortisone crystals in aqueous suspension intramuscularly in doses of 100 mg. daily for seven days, followed by a daily dose of 25 mg.

The excretion of 17-ketosteroids during the control period varied between 14 and 16 mg. per day. It decreased sharply to 6.3 mg. per day on the seventh day of treatment after 700 mg. had been given. When a total of 1500 mg. cortisone had been administered, the drug was discontinued. The average 17-ketosteroid daily excretion was 6.5 mg. during administration. Three weeks after cessation of the drug, the 17-ketosteroid level had risen to 11.5 mg. daily. During the periods of decreased ketosteroid excretion, the patient underwent a remarkable personality change. She became an outgoing, friendly, interested, jovial child characteristic of her chronological age of nine years. She maintained this attitude for six weeks after cessation of therapy and then gradually slumped to her pre-treatment personality. Cortisone was again obtained through the courtesy of the Savannah Health Center and daily oral doses of 25 mg. were started on February 15, 1951. There has been a suppression of the androgens and a satisfactory personality readjustment.

The metabolic balance studies made during the treatment on this patient were in no way controlled. However there was no appreciable alteration in the concentration of the serum electrolytes nor significant blood pressure or electrocardiographic changes. On the last day of initial treatment, during which time the patient had received over 1400 mg. cortisone, there were noted no changes in hirsutism or other clinical signs except some change in her facies. There was rounding of the face but subsequently this proved to be nothing more than an increase in weight. The typical Cushing's picture failed to develop.

Conclusions

A female pseudohermaphrodite who was found to produce excessive adrenal androgen as measured by urinary 17-ketosteroid was treated with cortisone, 100 mg. daily for seven days, followed by a 25 mg. daily maintenance dose until a total of 1500 mg. had been administered. This dosage suppressed the secretion of the adrenal hor-

mones responsible for the urinary excretion of 17-ketosteroids. This suppression lasted for approximately 13 days after discontinuing treatment. It has been suggested by Lawson Wilkins and his co-workers and borne out by this case that a 25 mg. cortisone daily dosage can maintain these patients for long periods of time without the production of unsatisfactory side effects.

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DISCUSSION OF PAPERS, "CORTISONE AND THE ADRENOGENITAL SYNDROME," BY PETER L. SCARDINO; "THE USE OF ACTH AND CORTISONE IN THE TREATMENT OF ANOREXIA NERVOSA," BY DRS. GREENBLATT, BARFIELD AND CLARK, AND "THE ADRENAL CORTEX AND ALLERGIC REACTIONS," BY WILLIAM F. FRIEDEWALD.

DR. V. P. SYDENSTRICKER, Augusta: You have heard of the remarkable somatic changes which may result from the administration of the hormones, and of the functional correction of dysfunction and lack of pituitary hormones. I think these are fundamental observations.

In the field of general medicine, one of the most interesting and still obscure effects of these drugs is their antiphyrgistic and detoxifying effects which already have been briefly mentioned. In states such as lobar pneumonia and typhoid fever, the toxic manifestations can be entirely relieved, although the patient remains bacteremic and severely and acutely ill from the standpoint of the physician, although quite asymptomatic from his own standpoint.

What the time is of humoral control of so-called toxic states exercised by these drugs, remains to be seen. The regulatory effect on abnormal cell production in occasional individuals is also a remarkable thing. Certain patients with acute leukemia, with myeloma, respond temporarily to an amazing degree, even to an apparent restoration of normal bone marrow over periods ranging perhaps from six weeks to ten or twelve months. In the fulminating relapse the effect of the hormones fails.

In certain so-called allergic manifestations, such as thrombocytopenic purpura and acquired hemo-

lytic icterus, similar beneficial results are obtained. We call these conditions allergic because we believe they are acquired and are antibody and antigen reactions. The reaction of hormones is still totally obscure, as Dr. Friedewald pointed out.

The wisdom of using hormones in acute infectious disease is likewise very doubtful, although at times one is tempted to try to ameliorate the toxic effects of severe infection while treating the infection with antibiotics.

I might mention that intense intoxication of severe tetanus may occasionally be relieved by cortisone. We recently had a patient with extensive burns of the legs which had been neglected, who came in apparently moribund with tetanus, having from five to ten seizures per hour. He was treated in the normal manner, anesthetized, his wounds debrided, a tracheotomy tube inserted because of his severe laryngotracheal spasm, given a lot of tetanus antiserum, and remained for about five days. Then he was started experimentally on cortisone, and he made a very dramatic and unexpected recovery. What the mechanism of a phenomenon such as this is, I am sure I have no adequate explanation.

Still more interesting is the apparent effect of cortisone or ACTH on the thyrotropic pituitary hormone in instances of so-called malignant exophthalmus, without manifestation of hyperthyroidism. So far we have treated only three patients with this condition, but have had very striking improvement in all. How long it will be maintained I am sure we cannot predict.

I am not qualified to discuss these drugs from the standpoint of an endocrinologist, but their

use or their apparent usefulness in such widely divergent conditions as disseminated lupus and malignant exophthalmus brings up one of the most fascinating chapters in medicine, in my opinion.

DR. MAX M. BLUMBERG, Atlanta: Dr. Friedewald's paper has much meat and few words. I didn't realize how voluminous the literature was until I reviewed the subject. Dr. Friedewald saved us all a terrific lot of time in reviewing such papers as Thorn's, Hench, Sayers, White and so many others.

I was very much interested, in the paper of Dr. Scardino. Often we see a patient with the condition that he presented, who comes to the office with various and sundry emotional problems and psychosomatic difficulties. It is hoped that with this additional form of therapy, maybe these patients will be much happier and less depressed, and will go through life in a much more normal manner from the standpoint of the psyche.

I would like to re-emphasize that these drugs do not cure the patient. I am glad Dr. Friedewald said that we almost but really do not know the mechanism exactly, and you may or may not approve of what looked like Rackerman's little diagram that he showed. You may be on one side of the fence, or the other, but at least these drugs don't cure the condition.

As Hench and others pointed out at the symposium at the Mayo Clinic last August, for the first time we have two natural agents with potential possibilities of reversing a disease such as rheumatic states and allergic conditions, and others, that we have never had before.

MEDICAL EDUCATION AND MEDICAL CARE DIVERGENCE OF OPINION OF MEDICAL FACULTIES AND PRACTITIONERS

R. HUGH WOOD, M.D., Emory University

THE close reciprocal relationship between medical education and medical care should be obvious. However, during the past decade there has been increasing evidence of conflicting opinion between those physicians engaged in medical education and those primarily concerned with medical care.

Various organized medical groups in recent years have expressed themselves in no

uncertain terms as to the needs and requirements of medical education. There is great need, therefore, for better understanding between practicing physicians and medical educators.

Medical Curriculum

Undoubtedly medical education must be geared to serve the needs of the nation for medical care. Both the number and kinds of doctors turned out by the medical schools must be predicated upon the national need. The curriculum must be planned with the needs of the patient in mind, since the pro-

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fessional product of the medical school will ultimately serve the patient as family doctor or specialist. But the undergraduate program of the medical school is not the place in which to train either the general practitioner or the specialist. Specialized training should be thought of as graduate training, a fact which apparently does not seem clear to many practicing physicians who perhaps are unfamiliar with the details of medical teaching. In several instances the establishment of a department of general practice, headed by a professor of general practice, has been recommended for medical schools. These recommendations were sincerely and honestly made in the effort to define the field of activity of the general practitioner and present the student with the required subject matter. By this proposed change in the undergraduate curriculum of the medical school, it was thought that students would be made acquainted with, and therefore be attracted to general practice as a career.

One instance in which this recommendation was formally made was at the 1950 meeting of the Southern Medical Association in St. Louis, when Dr. John O. Boyd of Roanoke, Virginia presented a paper entitled *Education in General Practice*¹. In this paper he strongly advocated a chair of general practice for all medical schools.

Another instance of formal recommendation is the report of the Committee on Medical Education of the Medical Society of North Carolina. Dr. R. B. Davis, chairman of this committee, presented the report which has been adopted officially by the House of Delegates of the Medical Society of the State of North Carolina. This report gives detailed recommendations for the content of a "practical medical curriculum." Knowing Dr. Davis personally, I am convinced that he is completely sincere, that he is interested in the welfare of the nation, and that he foresees the shortage of physicians. Particularly is he conscious of the need for more general practitioners in small communities. I cannot agree, however, with the method by which he chooses to remedy the situation. I have discussed the matter with him on numerous occasions and while we agreed on the need, we continue to disagree on the method to meet it.

I believe a division or department of general practice in the medical school, with a professor of this subject, is undesirable for several reasons. First of all, there is no well

defined body of knowledge which this department could embrace. The fundamental knowledge, skills, and techniques used by the general practitioner spring from every department of the medical school. Then, the medical curriculum is already crowded and in order to justify the introduction of a new division or course, better reasons must be given than those produced thus far by the proponents of a chair of general practice. The final application of basic knowledge derived from the four-year medical school curriculum must of necessity be learned by the graduate during his intern and residency years.

I fully agree that there are all too few well-rounded residency training programs for the general practitioner in this country. Medical schools are not without blame in this situation. For too long they have confined their interests to the campus and to the students, both undergraduate and graduate. It is time that the campus is extended to include community needs and medical services in the region in which the school is situated. We have made a small beginning in this direction at Emory under a Kellogg Foundation grant received some years ago. Under the direction of Dr. Russell H. Oppenheimer, we have endeavored to see what could be done to set up residency training programs for general practice in a few outlying hospitals, located some 50 to 100 miles from Atlanta. So far, we have met with scant success. One hospital has been approved for internship as a result of this effort.

No organized program has been set up in any of the other four or five hospitals which have been visited several times by Dr. Oppenheimer and other faculty members. One of the chief difficulties encountered was the lack of sustained interest on the part of the hospital staff to do the things necessary to deserve and receive interns. A few of these could be enumerated.

A hospital which deserves to have interns must require its staff to keep adequate records. Regular rounds must be made with the interns and a certain amount of instruction given in organized fashion. Medical, obstetrical, pediatric, and surgical conferences should be held at appropriate intervals and a clinical-pathological conference should be held at least once a month. In spite of the fact that such practices have been outlined verbally and in writing for many hospital staffs, only the one hospital

mentioned previously was able to institute a program of house staff training and this was accomplished after five years of negotiation. If a physician wishes to receive the benefit of a well-trained house staff in his hospital, he must be willing to give the necessary time and attention to the education of the interns.

Research

That research is related to medical care should be evident. A moment's reflection will show that many diagnostic and therapeutic measures in daily use by the physician were developed in the research laboratories of medical schools. Research is a necessary catalyst in creating an atmosphere conducive to learning. A practical reason why medical schools must maintain activity in research is the fact that they are unable to obtain faculty members unless the opportunity of research is provided. Most full-time members of the medical school faculties are on rather low salaries—considerably less than the income of private practitioners. Qualified medical teachers will not accept an appointment to nor remain on a faculty unless they are given the opportunity to carry out research projects in the laboratory. These statements are made since critics of medical schools have charged that the cost of medical education is unnecessarily high because of the excessive research activity of the faculty.

Financial Status of Medical Schools

Medical schools have been in increasing financial difficulty during the past ten years. It is a deplorable fact that the plight of the medical school is unknown to the general public and to most practitioners. This again is the fault of the medical school to a considerable degree. The schools have not stated their need nor told their story to the practitioners of the nation or to the public. It would be well to recall for you a few figures as to the cost of medical education and the financial need of medical schools.

The budgets of all the nation's medical schools for the fiscal year 1950-1951 totaled approximately \$67,500,000. Receipts from tuition totaled \$15,200,000. The mean tuition of the 79 medical schools in this country was \$554 for the year 1950-1951. These figures are contained in the Fiftieth Annual Report on Medical Education of the American Medical Association². It has been conservatively estimated that the average medical school spends about \$10,000 on the edu-

cation of each medical graduate over and above the amount paid by the student in the form of tuition. The Reed Report³ states that "Medical schools need an additional \$40,000,000 in current operating funds to perform their existing functions adequately."

In this area there is also a divergence of opinion between medical educators and practicing physicians. Federal legislation providing financial aid to medical schools has been opposed by the American Medical Association and endorsed by the Association of American Medical Colleges. There is no essential difference in the economic theories or political affiliations of these two groups. Most medical school faculty members are opposed to Federal aid to education. However, knowing the problem so well and seeing the danger clearly, they have expressed themselves as willing to accept Federal support as a last resort. To be realistic about it, political control of medical education may come through sources other than the Federal Government. Recently I was told by a professor of one of our Midwestern universities that his institution flatly was told by the State Legislative Authorities to increase the student enrollment if it expected to get additional appropriations for buildings. Yet, this school already has one of the largest enrollments in the country.

Sufficient funds for medical education must be made available if the present high level of medical care for the American people is to be maintained.

Summary and Conclusions

Medical education and medical care are inseparably related. Both practitioners and medical educators must bear this fact constantly in mind. The faculties of medical schools should bring their problems to the members of the medical profession; likewise physicians should make themselves aware of the problems of medical education. This is essential before organized groups of doctors formally present recommendations for changes in the medical curriculum.

The training of the general practitioner must be accomplished by a graduate program to follow graduation from medical school. The institution of a chair of general practice in medical schools does not seem to be justified.

The place of research in medical education has been defined, and its contribution to the practice of medicine and surgery as

well as to the education of medical students has been described.

Finally, the financial position of the medical schools has been discussed. The total amount of money spent for medical education is relatively small when its benefits are viewed in the light of national importance. By the same comparison the amount of money required to place the schools on a sound financial basis is even smaller. Ways to insure adequate support of medical education must be found in order to prevent deterioration in the quality of education and hence in the quality of medical care. Surely there must be some solution to the financial problem which will also permit educational institutions to preserve their freedom.

With better information and therefore better understanding of each others problems, sharp differences of opinion between medical school faculties and practitioners of medicine should cease to exist.

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DISCUSSION OF PAPERS, "MEDICAL EDUCATION AND MEDICAL CARE," BY R. HUGH WOOD; "PROGRAM FOR INTERN TRAINING FOR GENERAL PRACTICE," BY DR. G. L. KELLY, AND "THE ULTIMATE AIM OF VOLUNTARY HEALTH INSURANCE PLANS," BY W. S. DOROUGH.

DR. D. LLOYD WOOD, Dalton: Mr. Chairman and fellow members of the Association, these three papers have been excellent. Our medical

colleges—the two that we have in Georgia—in my opinion are doing splendid work.

I would like to emphasize the point made by Dr. Kelly, that in their senior year the seniors are getting domiciliary medicine. As all of us who do general practice know, we see things in the home and in the office that are not seen in the hospital. The intern and resident in the hospital gets the cases that are not treated in the home but in the hospital; so, they miss getting experience in many conditions that are never hospitalized but which we have to treat in general practice. That is a point I would like to bring out.

We need and must have more general practitioners. In my opinion it is absurd that a well trained medical college graduate of today can't do anything except treat the left eye, or confine himself to one small field. Yes, we must have the specialties, but the average doctor can take care of 90 per cent or more of the patients who come to the office or whom he is called to see. If the other cases are to be referred to a specialist, then let's have the specialist well trained. I think, too, that the best specialist is the man who has had some experience in general practice and who then specializes. He certainly seems able to do a better job.

I think we should feel very proud of the two medical colleges we have in Georgia today, and the training they are giving their students. I have had some opportunity to see the work they have been doing, and it is fine.

Concerning the prepayment medical insurance plan, let me request and urge all of you to sign up and join and cooperate with The Georgia plan. Dr. Dorough has done a lot of work on it. I think it is all to the good. I have been a member of that Committee. Please sign up for The Georgia plan.

Overworked Doctors

News reports say that Britain's "free" national health service is threatened with a mass withdrawal of doctors. The doctors—20,000 are now enlisted in the service—have many criticisms, including the fact that they are forced to do far more work for less pay than in the days before medicine was socialized.

The real victims of socialized medicine are the patients. An overworked doctor, forced under the panel system to attempt to treat an excessive number of people, will inevitably make mistakes, and patients who are seriously ill will not, in many instances, received the character of medical service they need. Moreover, under "free" medicine a dangerously large part of the doctor's time is taken up by people who have little or nothing wrong with them, and simply go to the office for examination because

it's something that they have coming to them.

Under socialized medicine, in addition, there has been a critical decline in research and in preventive medicine. Doctors simply haven't the time for it. And the British system offers small incentive to explore new worlds of medicine.

Finally, if the real costs are honestly counted, "free" medicine is mighty expensive in terms of money as well as in terms of substandard medical care. The bill is paid in taxes. In Britain's case, the actual cost of the service has run far beyond the optimistic estimates, and has been a major factor in her budget difficulties.

This country's proposed compulsory health insurance scheme follows that of Britain in many vital particulars. We don't want it here!—*Polk County Times*.

Special Articles

WHAT EVERY GEORGIA PHYSICIAN SHOULD KNOW ABOUT CIVIL DEFENSE

EDGAR M. DUNSTAN, M.D., Chairman

Medical Civilian Preparedness Committee, Medical Association of Georgia

IT is an accepted fact that physicians were the first to recognize and to call attention to the urgent need for civil defense planning on a nationwide basis. Perhaps this was partly due to the fact that many had served in World War II, had seen at first-hand the necessity for civil defense organization, and had had opportunity to study the effects of heavy bombing on the civilian morale in the United Kingdom, which had been preparing for this for years, as contrasted with that in Germany and Japan, where this was not anticipated.

The American Medical Association considered the matter thoroughly at the June 1947 meeting, and the House of Delegates authorized the Board of Trustees to appoint a standing committee to be designated as the "Council on National Emergency Medical Service". In September 1947 the following outstanding physicians were appointed on this Council: James C. Sargent, Milwaukee, present chairman; Winchell McK. Craig, Rochester; Harold S. Diehl, Minneapolis; Harold C. Lueth, Omaha; Perrin H. Long, Baltimore; Stafford Leak Warren, Baltimore, and Richard L. Meiling, Columbus, with the President and Secretary of the Association as ex-officio members. This Council has been very active with respect to medical and health aspects of civil defense, advising with Federal authorities on over-all planning urging the appointment of and instructing State Emergency Medical Service Committees in the steps to be taken to be of maximum assistance in this vital field.

The Medical Civilian Preparedness Committee of the Medical Association of Georgia was appointed in May 1949, with the following as its initial members: Doctors Edgar M. Dunstan (Chairman), Robert W. Candler, Charles E. Dorman, Joseph S. Skobba and Walter M. Bartlett. This committee was instructed to study the problems connected with the emergency medical care for civilians in case of disaster within this state, to cooperate with the governmental authorities in setting up an adequate civil defense organization, and to recommend plans for supplying the necessary professional personnel that will be needed. The original committee was enlarged the follow-

ing year by the appointment of Doctors Alvin E. Siegel, Macon, J. H. Pinholster, Savannah, W. A. Philpot, Augusta, and T. J. Ferrell, Waycross.

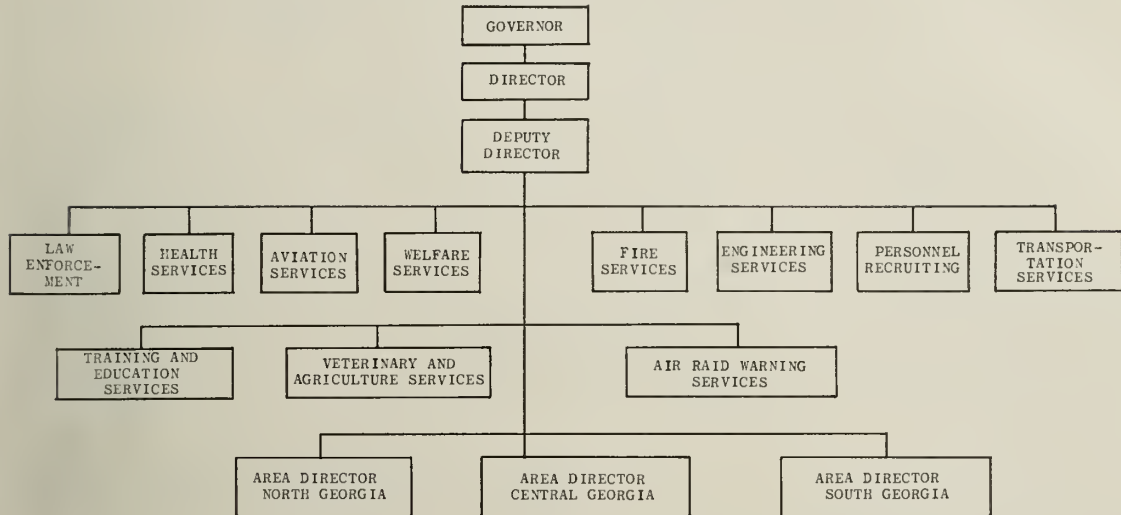
A summary of the activities and recommendations of the Committee appears in the reports to the House of Delegates of the Medical Association of Georgia. The committee mailed to the Secretaries of all component societies a tentative plan for the utilization of medical personnel in event of disaster which was based largely on the one adopted by the Maine Medical Association, which pioneered in this field. The publication of the federal manuals "United States Civil Defense" and "Health Services and Special Weapons Defense" in September and December 1950, respectively, made it desirable to modify this tentative plan slightly to bring it in line with their recommendations. The essential features of this plan are outlined below.

After prolonged study the Federal Government published "United States Civil Defense", and in December 1950, the President set up the office of Civil Defense Administration and appointed Mr. Millard Caldwell Jr. as administrator. The country was divided into regions and Mr. Wiley Moore of Atlanta has been appointed as Administrator of the Southeastern region, including the states of South Carolina, Florida, Georgia, Alabama, and Tennessee. It is anticipated that one of the large regional federal supply depots will be established in this state, near Atlanta. In this connection, we are especially fortunate in this state in having one of the main Army supply depots located at Conley, Georgia, and presumably could count on some initial aid from it in event of disaster until our resources could be fully mobilized.

On February 19, 1951, Governor Herman Talmadge, signed the Georgia Civil Defense Act of 1951, and thus officially set up the Civil Defense Division of the Department of Public Defense in this state. The Adjutant General, Major General Ernest Vandiver, as executive head of the Department of Public Defense of this state, became the Director of Civil Defense and Brigadier General Frank A. Kopf, who has acted as co-ordinator in the planning period, has been appointed as full-time Deputy Director of Civil Defense. An Advisory Council of 20 members has been appointed. Most of the 180 local civil defense directors for cities of 1,000 population and over have been

Read before the Medical Association of Georgia in Annual Session, Augusta, April 19, 1951.

CHART 1
STATE CIVIL DEFENSE ORGANIZATION



appointed as well as the 26 county civil defense directors for counties not having cities of 1,000 or more population. At present, the state has been divided into 3 district areas, namely, the Atlanta (northern), the Macon-Augusta, and the Columbus-Savannah areas, headed by area directors Gerald D. Cauble, M. L. Leggett, and Harry J. Jackson, respectively.

Dr. T. F. Sellers, State Public Health Officer, has been appointed Director of the Health Services Division, Dr. L. M. Petrie, Director of the Industrial Hygiene Division of the State Public Health Department, was appointed Deputy Director and

the following have been appointed as assistant directors: Dr. Cliff Rutland, for the Public Health Services Branch; Dr. W. J. Murphy, for the Special Weapons Defense Branch; Dr. C. D. Bowdoin, for the Health Supplies Branch; and Dr. Edgar M. Dunstan, for the Medical Services Branch. Doctors Rutland, Murphy and Bowdoin are members of the staff of the Georgia Department of Public Health. These, in turn, have organized their respective branches in accordance with the recommendations of "Health Services and Special Weapons Defense". The organization charts shown above and below are self-explanatory.

CHART 2
HEALTH SERVICES DIVISION ORGANIZATION

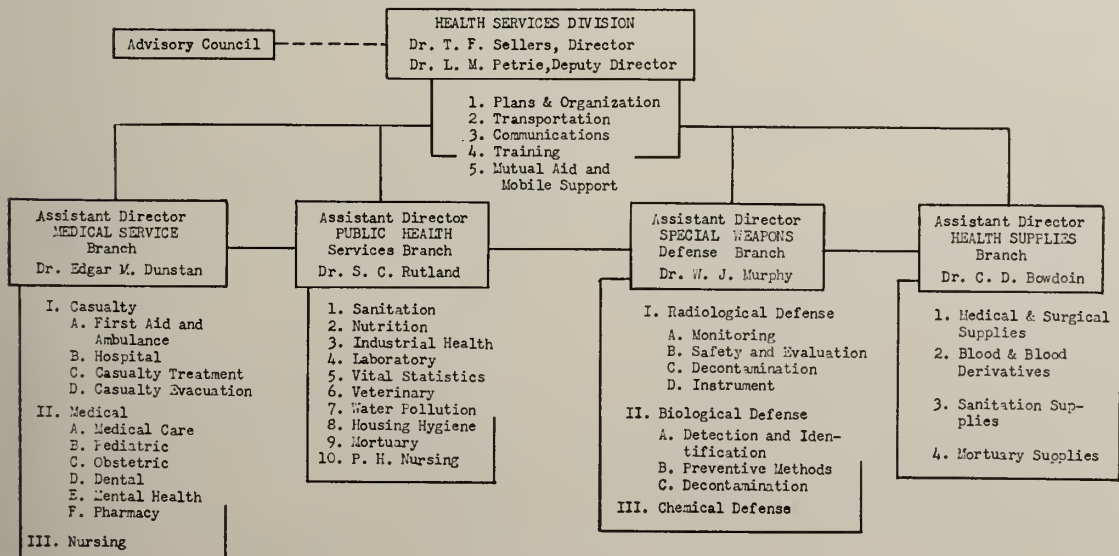
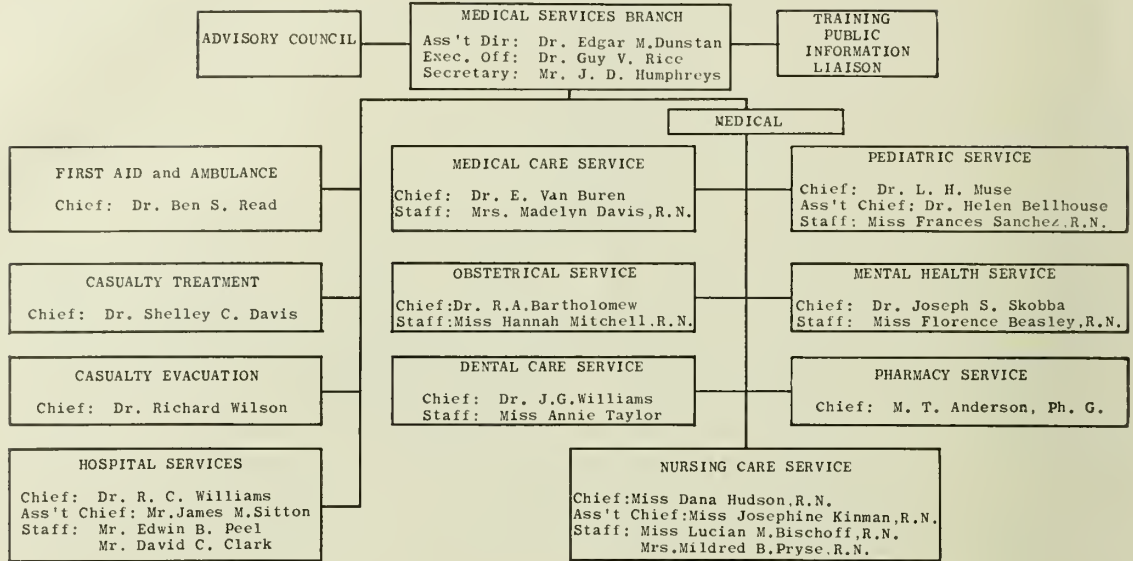


CHART 3
MEDICAL SERVICES BRANCH ORGANIZATION



The Health Service Division has already had several meetings and the different branches are actively engaged in securing basic data on personnel, installations, equipment, and supplies and working on an over-all plan, to be published later, to provide maximum assistance to local civil defense organizations and coordinate state-wide efforts in this respect. At present the activities of this division are summarized in a bulletin entitled "Civil Defense Health Services". The five regional public health districts are to be organized along the same pattern as the State organization, the personnel are to act as alternate CDHS directors and chiefs of services, and information accumulated is to be passed on to all of these. This decentralization will permit the services to function even if the central organization is destroyed. The five districts with their headquarters and directors are as follows:

Dr. W. S. Cagle, Northwest Region, Rome; Dr. W. B. Harrison, Northeast Region, Athens; Mr. E. G. Eggert (acting), Central Region, Macon; Mr. Larry Tabor (acting), Southeast Region, Waycross; and Dr. O. F. Whitman, Southwest Region, Albany.

The Georgia Civil Defense Act of 1951 follows closely the recommendations contained in the Model Act recommended in "U. S. Civil Defense". It gives the Governor of the State very important powers and duties in case of any emergency. Among these are:

1. To have general direction and control of the Civil Defense Division and shall be responsible for carrying out the provisions of this Act; to cooperate with all the departments and agencies of the Federal Government, with the offices and agencies in other states and with private agencies in all matters pertaining to civil defense of the state and of the nation.
2. To make, amend, and rescind the necessary orders,

rules and regulations to carry out the provisions of this Act.

3. To prepare a comprehensive plan and program for civil defense of this state.
4. To procure supplies and equipment, to instigate training programs, and public information programs, and to take all preparatory steps including the partial or full mobilization of civil defense organizations in advance of disaster, in order to insure the furnishing of adequate trained and equipped forces of Civil Defense personnel in time of need.
5. To conduct such studies and surveys and to take such inventories of the industries, resources, and facilities of this state as may be necessary to ascertain the capabilities of the State Civil Defense and to plan for the most efficient emergency use thereof.
6. To enter into mutual aid agreements with other states and to coordinate mutual plans between the political subdivisions of this state.
7. To create and establish such number of mobile reserve battalions as may be necessary to re-inforce civil defense organizations in stricken areas and in accordance with the plans of the Federal Government.
8. To delegate any authority invested in him under the provisions of this Act, and provide for sub-delegation of such authority.

In the event of actual enemy attack upon the State of Georgia, and against the U. S., the Governor may declare that a state of emergency exists and he may then exercise the following additional emergency duties:

1. To enforce all laws, rules, and regulations relating to civil defense and to assume direct operational control of all Civil Defense forces and helpers in the state.
2. To seize, take for temporary use or condemn property for the protection of the public in accordance with condemnation proceedings as provided by law.
3. To sell, lend, give, or distribute all or any such property among the inhabitants of the state, to account to the State Treasurer for any funds received for such property.
4. To perform and exercise such other functions, powers, and duties, (including traffic control), as may be

deemed necessary to promote and secure the safety and protection of the civilian population.

The Georgia Civil Defense Act of 1951 also provides for local organizations for Civil Defense as follows:

1. Each city of this state, having a population of 1,000 or more, as well as others specified by the Governor, is not only authorized but directed to establish a local organization for Civil Defense, nominate a director who shall be appointed by the Governor, and who shall have direct responsibility for the organization, administration, and operation of such local organizations for civil defense, subject to the direction and control of such governing body.
2. The Director of each local civil defense organization, in collaboration with other public and private agencies within this state, may develop or cause to be developed Civil Defense plans and programs and mutual aid arrangements for reciprocal Civil Defense aid in case of disaster too great to be dealt with unassisted, and in accordance with the policies and plans set by the Federal and State civil defense agencies.
3. Each local organization is authorized to establish a primary and one or more secondary control centers to serve as command posts during an emergency.

There are, of course, many other less important provisions of this Act which can be found by careful reading of the Act in its entirety. In time of duly proclaimed emergency in Georgia, it is quite clear that the Governor, or his properly authorized representatives, has essential dictatorial power and can enlist the necessary personnel and procure the supplies and equipment needed in efforts to control the disaster. The law enforcing authorities of the state and municipalities are instructed to enforce the orders, rules and regulations issued pursuant to this Act.

In several conferences with Brigadier General Frank A. Kopf, State Deputy Director for Civil Defense, he has stressed his basic philosophy with reference to Civil Defense. First and foremost he regards it as a civilian responsibility, a major premise now written into law and upon which all authorities now agree. Further, he considers that it is primarily a local problem and that the state organizations exist essentially to offer advice and guidance and coordinate the efforts of the local organizations. He believes in making maximum use of existing set-ups and facilities for Civil Defense. He considers that one of the main objectives in case of major disaster is to prevent panic and this can be done most effectively by education. He has already had published and is distributing several small practical pamphlets stressing defense measures in case of atomic attack. He is encouraging mutual aid agreements between local communities.

His other important major activities at the moment are the completion of his central organization,* the setting up of air-warning stations at 8 mile intervals and the organization of three

mobile battalions (eventually 5 or more) one for each civil defense district area. Each of these mobile battalions is thoroughly organized with proper tables of organization and equipment. It contains, in addition to the headquarters with its maintenance and supply sections, service teams for installation repair service, medical service, fire-fighting service, rescue service, food service, chemical decontamination, radiological service and police service. The total personnel of these civil defense mobile support groups is 514 of which 68 are assigned to the medical service team.

The proposed plan for utilization of medical and allied personnel, prepared by our committee and subject to further consultation with the Medical Association of Georgia and approval by the State Civil Defense authorities, revolves around thorough cooperation between the state and county medical associations and the general hospitals in the State, as follows:

1. *General hospitals to be requested to:*
 - a. Cooperate with the Medical Association of Georgia, in an effort to work out a plan to provide emergency medical care for civilian disaster casualties within this state.
 - b. Set up a comprehensive hospital plan with standard operational procedures (SOP) with the least possible delay, which SOP will provide a detailed outline of procedure to be carried out in case of disaster in their locality or assist other areas when needed.
 - c. Prepare:
 1. Plans for maximum expansion of present bed capacity.
 2. Develop plans for evacuating occupied beds if disaster strikes.
 3. Select alternate hospital sites if transfer becomes imperative.
 4. Train additional personnel such as: laboratory technicians, surgical assistants, practical nurses, anesthetists, and volunteer auxiliary workers.
 5. Make immediate and continuous inventories of existing and reserve supplies and equipment available in their areas, evaluate ability of resources to satisfy both current and anticipated needs, and study availability of substitute resources, particularly in suburban areas. Where there is more than one general hospital in a county, it is suggested that the large amount of work required in this connection be allocated to each hospital by a Council of Hospital Superintendents, or under their direction.
 6. Have this material in such state of readiness at all times that up-to-date information can be given quickly to Civil Defense authorities upon request.
2. *Organization of active staff members of general hospitals for emergency duty.*
 - a. In case of major disaster, the Medical Director or Superintendent of each general hospital should be requested to summon the Chiefs of Medicine, Surgery, Pathology and X-ray, or their specifically designated representatives, who upon consultation, will determine when to put the Organization for Disaster Plan into operation. This plan as set up in "Health Services and Special Weapons Defense (p. 74)" is set up according to the chart on page 430.
 - b. The composition of the basic teams of the disaster organization should be equivalent to an operating room team which should consist of a surgeon,

*The State Civil Defense Plan was released June 1, 1951 (approx.).

minimum of supplies will always be on hand. Also, each physician and dentist would be expected to have on hand at home a bag containing essential first-aid equipment for ready use at all times regardless of whether or not he becomes a casualty.

- d. Mobile first-aid units have been recommended by "Health Services and Special Weapons Defense" as the method of choice, these to be arranged in two circles, 1½ miles and 2 miles from Ground Zero, and the units to be 1/6 mile apart in the first ring and 1/3 mile apart in the second ring when used in the disaster area. The limited local civil defense funds available make this impossible at this time at the local level. However, it is felt that many medium-sized communities in Georgia, if approached properly, would like to sponsor one or more such units of the State CDVMS Corps. Civic club sponsorship is particularly desirable because these often include in their membership representatives from companies which use routinely much of the heavy equipment and supplies that will be needed.

The personnel required for round-the-clock operation of such a unit is:

Physicians	2
Dentists	3
Nurses	3
Pharmacists	2
First-aid workers and nurses' aides	15
Clerical assistants	6
Litter bearers	150
Ambulance personnel	8
(2 four-stretcher ambulances—2 attendants each)	
(4 automobiles—1 attendant each)	

The estimated requirements of other equipment and supplies needed are given on pages 57 to 59 of "Health Services and Special Weapons Defense".

The Medical Civilian Preparedness Committee believes that it is imperative that the physicians of Georgia understand their obligations and accept, of their own free will, their great responsibilities in connection with civil defense. There is no longer reasonable doubt that atomic warfare will come to our cities. Preparation for treatment of the expected 60,000 or more casualties should not be left to chance.

Every physician can help by:

1. Giving full cooperation to their local civil defense organization, accepting the necessary assignments, and seeing that there is an active medical advisory committee available to the civil defense director at all times.
2. Participating and encouraging the training programs for physicians, nurses, technicians, other auxiliary hospital personnel, Red Cross first-aid, home nursing and nurses-aide courses for laymen, and public information programs. Physicians are urged to request their district headquarters for speakers who have taken the courses in medical aspects of atomic warfare; they will have the list of the men in their districts who are qualified to teach these subjects. In many phases of this work, particularly the public information phases, the Women's Auxiliaries of the State and County Medical Societies and of the hospitals, as well as the Better Health Council of Georgia, can be of inestimable aid.
3. Organizing their respective hospitals and county medical societies in line with the recommendations above made for the handling of disasters.
4. Contributing to the prompt formulation of a comprehensive disaster plan for their respective hospitals.
5. Taking an active part in soliciting their respective patients and friends to participate in the Red Cross Blood Donor Program.
6. Studying the manual "Health Services and Special Weapons Defense" to get the over-all picture of health

services organization; this manual can be obtained from the U. S. Government Printing Office, Washington, D. C., for \$0.60. In addition, it would be well to order copies of the State of Georgia Civil Defense Plan and the Georgia Civil Defense Act of 1951 from the Civil Defense Division, Department of Defense, 410 State Office Building, Atlanta, Georgia. Also, by writing Dr. L. M. Petrie, Deputy Director of the Civil Defense Health Service Division, State Office Building, Atlanta, Georgia, he will send you upon request a copy of the excellent Medical Aid Plan for the Atlanta Metropolitan Area prepared by Dr. Charles Eberhart and his committee, after about one year of intensive study; this can give many suggestions that will aid other local organizations in formulating their own medical aid plans.

7. By being sure to keep up with current civil defense health activities and further reference material by getting on the mailing list of the bulletin "Civil Defense Health Services" issued from the office of Dr. L. M. Petrie at the above state address. Here will be found reports of the current work of each service in the Health Service Division.

As examples, Dr. R. A. Bartholomew is working on the medical phases of the proposed State Evacuation Centers for the evacuation of pregnant women (over 5 months), children, and certain specified chronic infirmities. Dr. L. H. Muse, Mr. Edwin Peel and Miss Dana Hudson have just completed the Georgia Baptist Hospital Disaster Plan, which can serve as a guide for similar Georgia Hospitals of 25 to 50 bed capacity.

Dr. Muse is also working on pediatric mass immunization problems. Dr. Richard Wilson is working on assignment of physicians to the different units of the Georgia State CDVMS Corps. Dr. Shelley Davis is preparing a manual for the emergency treatment of mass casualties. Miss Dana Hudson is rapidly expanding the courses on "atomic nursing" with the objective of having every Georgia nurse have this course by the end of this year. Dr. R. C. Williams and his hospital service staff are preparing plans to assist hospitals in their vital assignment. Dr. Ben Read is working on plans for setting up mobile first-aid stations in medium-sized communities. Dr. Joseph Skobba is studying the matter of establishment of psychiatric clinics for the large number of these cases expected. Pending the publication of an over-all health services plan, each service will welcome inquiries and suggestions and will gladly advise with local planners upon request.

Conclusions

1. A comprehensive Civil Defense Act has been passed by the 1951 Georgia Legislature which fixes responsibilities, provides for administration, allocation of funds, gives legal authority for procurement of personnel, equipment, and supplies, establishes penalties for non-compliance, encourages mutual-aid agreements and provides for inventories, studies, and surveys upon which to base planning for the most efficient emergency use of facilities available.
2. The Civil Defense Division for Georgia has been set up, in accordance with the organiza-

tion tables shown and is functioning.

3. Practically all of the Local Civil Defense Directors have been appointed.
4. Mobile battalions of 514 men are being organized, one for each of the present three Civil Defense district areas.
5. The Medical Civilian Preparedness Committee

of the Medical Association of Georgia has made recommendations for providing the medical personnel that will be needed for operation of the different units that will be required in case of major disasters in this state, and has indicated how every physician can aid in, and keep abreast of this vitally urgent work.

THE 'NEW' GEORGIA BAPTIST HOSPITAL

EDWIN B. PEEL, *Atlanta*

EDITOR'S NOTE: On Thursday, November 29, at 2 p.m., the cornerstone of the fine new building of the Georgia Baptist Hospital in Atlanta will be laid. The occasion is the 50th anniversary of the founding of the institution. At this time the public is cordially invited to inspect the physical facilities of this modern hospital. Below, Edwin B. Peel, superintendent of Georgia Baptist, describes some of the features of the building and gives a brief history of the development of the institution.

THE "New" Georgia Baptist Hospital expansion program, when completed within the next few weeks, will represent 191,844 square feet of floor space on eight floors. The new addition to the plant will be completely air-conditioned and as modern as was humanly possible to construct. The new addition represents 363 beds and 56 bassinets, making the overall capacity of the Georgia Baptist Hospital 505 beds and 56 bassinets, and it constitutes a complete general hospital.

The exterior of the building is of the latest modern architectural design, and has received an award of merit from the American Institute of Architects for 1951.

The major changes that are evident in several departments are:

In the surgical suite all operating rooms are of the same size, so that there is no distinction between major and minor surgical units. Each operating room has a centralized control panel for all the facilities to feed out to the operating table in one small restricted area. In addition to the above, the substerilization and scrub areas are completely new and modern so that the surgeon is aware of all techniques that are being carried out and can observe each of these procedures as he enters the operating room or while he is scrubbing for the procedure he is to undertake.

The central supply layout is designed for maximum utility and for the assembly line technique for normal flow of preparation of materials through the sterilization process itself and eventually back to the place of usage.

The nurses' stations are redesigned and offer a restricted area for keeping charts. The utility

and medicine rooms and charting areas are definitely divided. Each nurses' station has adjacent to it a treatment room for the use of the physician in handling minor procedures on each floor.

A pneumatic tube system has been installed which will facilitate the handling of messages from each department and the distribution of some smaller articles.

Each floor of the new addition is designed for maximum service to the physician, the patient, and the visitor. A public waiting room and a solarium are on each floor, along with a family room to be used by the physician in consultation or by the family group at times of sorrow.

Each patient's room has rubber floor covering, plastic wall finish, acoustical ceiling treatment, two-way nurses' call communication system, and oxygen piped in from a central storage unit.

On the eve of the laying of the cornerstone of the new structure, it is appropriate to note certain historical facts regarding the birth and growth of this hospital.

Dr. Len G. Broughton, Pastor of the Baptist Tabernacle Church, Atlanta, himself a physician, in 1897 opened the Infirmary Training School on McDonough Road. On Thanksgiving Day, 1901, the Infirmary was moved to a five-room cottage on Courtland Street and the name of the original institution changed to the Baptist Tabernacle Infirmary.

Asked the following morning, "What do you have with which to start a hospital?", Dr. Broughton replied, "Sick people, and the command of Christ" (Matthew 10:8). Thus began the institution with the one avowed purpose of serving humanity to the glory of God.



The spirit of this institution, which celebrates its 50th birthday anniversary on November 29, 1951 with the laying of the cornerstone of the magnificent new building, is very aptly expressed in the following lines by Elizabeth Barrett Browning:

A poor man served by thee
Shall make thee rich.

A sick man helped by thee
Shall make thee strong.

Thou shalt be served
Thyself by every sense

Of service which
Thou renderest.

The first two women received into the Home established in 1897 were opium addicts, and during its ministry from 1897 to 1901, the Home ministered to more than 300 women. Mrs. Walton H. Wiggs served as President of the Board of Lady Members of the Home for Helpless Women, and when the Baptist Tabernacle Infirmary was established in 1901, Mrs. Wiggs continued her work with the enlarged institution, giving of her money and time and prayers, as did many other noble women of the Baptist Tabernacle and neighboring churches. In 1903, the Infirmary was moved from the Courtland Street Cottage to the Rex Hotel property, next door to the Y.M.C.A. building at 162 Luckie

Street. In 1903, the Infirmary was moved to 69 Luckie Street, next door to the Tabernacle Baptist Church.

The first staff was composed of the following physicians and surgeons: Drs. Monroe Smith, J. N. Brawner, J. M. Crawford, H. R. Donaldson, R. R. Kime, E. C. Davis, J. D. Cromer and A. E. Wheeler, and Dr. Joseph Broughton, dentist.

A clinic was conducted every day from 12 to 2 o'clock for treatment of the poor, without charge. The capacity was 20 beds, and patients were admitted without regard to their ability to pay.

The Woman's Auxiliary was organized in 1903. The following year, 15 rooms were added to the Infirmary and an elevator was installed, as well as a laundry and other essential equipment. Dr. Orr was the first intern, beginning his work in July 1904. On November 16, 1904, the Infirmary graduated its first class of trained nurses.

In March, 1913, the Georgia Baptist Convention bought the Tabernacle Baptist Infirmary on Luckie Street, consisting of a three-story brick building with accommodations for 64 patients and a frame structure with 12 rooms for nurses, for the sum of \$85,000. The institution's name was changed to the Georgia Baptist Hospital.

On Christmas Day, 1921, the Hospital was moved from Luckie Street to the present location, 450 East Avenue, in Atlanta.

In 1922, the Trustees found themselves unable

to carry on the Hospital, because of financial emergencies, and the Georgia Baptist Convention placed the operation of the Hospital in the hands of a Hospital Commission.

In 1931, Dr. O. D. Hall gave the Hospital radium valued at \$11,000. As a result, the Atlanta Cancer Clinic was established at the Georgia Baptist Hospital in 1934, through the gift of Mr. I. M. Sheffield, Sr.; known as the Sheffield Clinic. Dr. J. L. Campbell was named Director of the Clinic, with Dr. O. D. Hall as Associate Director. This was the first tumor clinic established in Georgia, and the first cancer detection clinic established in this section.

In 1943 a movement was launched by the Hospital Commission—Louie D. Newton, Chair-

man, I. M. Sheffield, Wiley L. Moore, Dick H. Hall, Jr., and James W. Merritt—to raise \$1,000,-000 for the "New" Georgia Baptist Hospital. On August 27, 1948 ground was broken for the new hospital.

Although the hospital was eligible for Federal funds under the Hill-Burton Act, the Commission declined to apply for any Federal aid, holding to the cherished Baptist principle and practice of separation of church and state. Had Federal funds been accepted, the entire building would now be paid for; but the Commission believes that it is better to do it the hard way, thus maintaining a priceless principle of religious liberty. Credit for this new hospital must be given to the Hospital Commission.

THE MANAGEMENT OF SMALL TUMORS

CANCER COMMISSION, MEDICAL ASSOCIATION OF GEORGIA

THE annual meeting of the Georgia Division of the American Cancer Society held in Atlanta, September 14, was one of the most successful meetings of its kind ever held. The attendance was excellent and was extremely well-balanced, having doctors, businessmen and women volunteer workers in almost equal quantities. The scientific meeting held for the doctors was attended by over a hundred members of the medical profession. The cases presented by the Atlanta state-aid Clinics were well selected, had been well worked up, and were presented in good fashion by the particular doctors who had been assigned this duty. Dr. Lee Clark, who led the discussion panel on these cases showed that he is a man extremely well-versed in all varieties of cancer, having wide experience and good judgment. Those who failed to attend missed an excellent opportunity to hear many phases of cancer diagnosis and treatment discussed in an excellent manner.

One of the cases presented was a case of metastatic melanoma, and the history of this patient revealed that a lesion, apparently completely benign with none of the usual suggestive findings of either a melanoma or a malignant melanoma, had been destroyed by electrocoagulation. It later recurred, was biopsied, and was found to be a malignant melanoma. From this, the patient's numerous metastatic areas, which had been removed by surgery with at least temporarily good results for the patient, had arisen. This brought up the thought that the first doctor who sees or treats any lesion on the skin or near the skin has a great responsibility to his patient. If there is the slightest doubt as to the nature of the lesion, and there usually is, this lesion should be removed with sufficient margin of skin and sufficiently deep

to preclude aggravating or actually spreading a malignant lesion, which up to that time, had possibly been completely localized. Even where lesions that are apparently completely innocuous and benign are to be destroyed by electrocoagulation for cosmetic purposes, it would often be very wise to remove a small piece of this lesion for pathological examination before proceeding with the destruction of the remainder of the lesion by electrocoagulation. In this manner, if one has been in error in their judgment, the error is quickly discovered, and remedial steps can be taken immediately, rather than waiting for a recurrence or a metastasis to instigate the proper treatment.

There are many small lesions which occur near the skin, such as lipomas, fibromas, sebaceous cysts, sweat gland cysts, and so-called neurofibromas. Most of these lesions are first seen and a large number of them are removed by general practitioners or general surgeons. All of these lesions have a possibility of being malignant and should be sufficiently widely removed to be sure that there is no danger of cutting through and closing up malignant tissue. In considering these lesions, it is well to remember that most textbooks state that one of the criteria for benign lesions is the presence of a capsule. This, of course, pathologically, is absolutely true; however, clinically, it is impossible to differentiate an actual capsule from proliferation of fibrous tissue stimulated by the growth of a neoplasm. The lipoma is a very good illustration of this, although it may occur with fibrosarcomas and other lesions. When these neoplasms grow very rapidly, there is a tendency for them to push out and produce a stimulation for fibroblastic incapsulation, which can very easily stimulate a true capsule. To go back

to the lipoma—the benign lipoma rarely shows a very distinct capsule. The capsule around this tumor is no more noticeable, usually, than the fibrous incapsulation of any other lobule of fat. However, when a liposarcoma develops, most of its activity is at the periphery. It has a tendency to reach a more or less adult condition in the center, and to confine its malignant potentialities to the peripheral growth zone. This rapid growth in the periphery produces a fibroblast response which causes an unusually heavy incapsulated appearance. It is in this capsule that the most malignant of the cells are located, and finding such a capsule around a lesion which has all the other appearances of a lipoma, should make one decide to remove this tissue with a good margin

of normal fat and also to strip the fascia from beneath the tumor, removing the entire amount of tissue in mass. There is a tendency with each recurrence of a lipoma for its growth potential to be increased, until finally there can apparently arise a highly malignant liposarcoma from what was originally a very innoxious benign lipoma. The important thing to remember about a capsule around a superficial tumor is not that it indicates a benign growth, but that it could possibly be a fibroblast response to a highly malignant growth. It is just as easy to extirpate these tumors with a safe margin as it is to peel them out from the inside of the capsule, and this will add a great deal of margin of safety to the patient.

Complete wide removal of small tumors may prevent the development of fatal cancers.

MILK THROUGH THE AGES

L. M. CLARKSON, *Director*

Public Health Engineering, Georgia Department of Public Health

MILK is as old as the mammals and as old as the origin of man. It is the only food prepared specifically by nature for the young of mammals. No other food is more important.

With one notable exception, the milk of mammals is regularly consumed only by the young. Man, however, learned centuries ago that the milk of other mammals, particularly the cow, is an excellent food for persons of all ages. Accordingly, the cow was tamed and became one of the most important sources of food for the human race.

Man's dependence on the cow for food dates far back into the past. References to herdsman are found in the earliest writings 3,500 years before Christ. From that time on down to the present, across the continents of the world and through the pages of history, the path of the cow paralleled that of man. During the course of that long association different peoples paid tribute to the cow in different ways. In a few countries man's esteem for the cow was so great that she became an object of worship.

Not all peoples utilized the cow as a source of food. Those who failed to do so, however, paid a price for their neglect. Milk drinking peoples are larger and more robust than their non-drinking neighbors. They are also healthier, more aggressive and more prosperous. There is little doubt that these characteristics are due in part to superior nutrition.

As for our own country, the cow appeared on the scene almost as soon as the white man. On his second voyage to America, Columbus brought a few cows with him and left them on the Island of San Domingo. The Pilgrims, on the other hand, brought no cows with them and it is believed that

faulty nutrition contributed materially to the high death rate among their children. This experience was not ignored by later immigrants. It was also remembered by the early pioneers who settled in the West. As these settlers migrated westward in covered wagons the cow went along with them.

Today, 51 billion quarts of milk are being produced annually in this country. Almost one-fourth of this amount remains on the farm where it is consumed as milk and cream, made into butter or used for feeding calves. Of the total annual production, butter requires about 32 per cent, fluid milk for drinking and cooking about 30 per cent, cheese 6 per cent, canned milk 4 per cent, and ice cream 3 per cent. Milk and milk products account for about 20 per cent of the food consumed by the average American.

Milk is the largest single source of farm income. Moreover, the dairy industry is continuing to grow. At the present time, milk is being produced on about three-fourths of the nation's 7 million farms.

The importance of milk in the diet of the average American makes it imperative that proper safeguards be employed to prevent the transmission of disease. Milk is not only a good food for man and animals; it is also an excellent medium for the growth of harmful bacteria. Possible sources of contamination include the cow herself and all persons engaged in handling the milk.

The milk sanitation program of the State Health Department provides advice and assistance to local health departments in all matters relating to sanitation. The services of two mobile milk laboratories are employed for that purpose. These mobile laboratories, together with specialized milk sanitation personnel, are stationed in local communi-

ties for periods of 30 to 60 days or longer. During that time all dairies in the area are inspected. Milk is tested routinely for total bacteria, specific types of bacteria, sediment, temperature, excess water, and for efficiency of pasteurization. At the same time, educational opportunities are not overlooked. Milk sanitation problems are discussed with all those engaged in the milk industry and, as a consequence, milk producers are being trained in milk sanitation.

One of the notable accomplishments of the laboratory service has been the great reduction of excess water in market milk. Of 2,490 milk samples examined during 1950 for excess water, 750 or 30.1 per cent showed excess water ranging from 3.3 per cent to 41.5 per cent. The elimina-

tion of this situation is obviously to be desired.

An effort is also being made to obtain more uniform interpretations of milk ordinances so as to facilitate the movement of milk from one city to another. This has been a retarding factor for many years and can only be remedied by reciprocal recognition of milk supplies among the various cities, communities, and local health departments throughout the state.

A milk sanitation program which prevents illness on the one hand and promotes nutrition on the other is obviously a valuable public health service. It is the purpose of the Department of Public Health to expand this service and to exercise every means possible to make Georgia's milk supplies the equal of any in the nation.

CLINICAL HEADLINES

Present Antimalaria Research

Chloroquine is an excellent suppressant; but, like atabrine and quinine, it is neither a preventive nor a complete cure for malaria. Since the standardization of chloroquine in 1947, the Army Medical Service has concentrated much of its research on a new drug, primaquine, which seems to offer much promise in the treatment of malaria. Primaquine appears particularly effective against the tissue phase of the disease because it attacks the stubborn parasites in the liver cells. It may thus be possible to effect rapid cures for malaria and prevent numerous relapses by simultaneously treating the parasites in the blood stream with chloroquine and those in the liver with primaquine.

If primaquine proves successful, it will not replace chloroquine as a suppressant, but it may be possible to administer it routinely to all persons returning from malaria-ridden areas and, in effect, cure the disease before the returnee knows he had contracted it.

Studies Caffeine-Containing Drinks

To further develop a diagnostic test for peptic ulcer, where ulcer cannot be demonstrated by x-ray, and to determine whether the daily consumption of relatively large quantities of caffeine-containing beverages over a long period may contribute to the cause of peptic ulcer, will be the main purposes of an investigation at the Graduate Hospital in Philadelphia. Previous work has shown that caffeine is capable of producing gastroduodenal ulcers in cats under special conditions; that caffeine provokes vascular changes in cats which increases the flow of blood to the mucous membrane and makes it engorged and succulent. These last changes are similar to those induced in many by prolonged

resentment, hostility and anxiety—the major emotional factors involved in the genesis of peptic ulcer.

Chloromycetin Aids Hurricane Areas

Parke, Davis and Company has given 10,000 doses of its life-saving antibiotic, Chloromycetin, to hurricane-hit Jamaica, British West Indies, and Tampico, Mexico. Chloromycetin was used to combat typhoid and other diseases which flare up in disaster areas. The antibiotic already has been found effective in the treatment of over 30 different diseases.

Polio, Tuberculosis Death Rates Drop

Death rates in the United States for several important diseases—including acute poliomyelitis, tuberculosis and measles—fell significantly in 1950 compared with 1949, according to vital statistics compiled by the U. S. Public Health Service. The death rate for acute poliomyelitis fell off by 39 per cent in 1950, the tuberculosis death rate by 16 per cent, and the death rate for measles was cut in half, coinciding with a decline in the number of cases of measles in 1950.

Other important causes of death with decreases in death rates were gastritis and some intestinal diseases, cirrhosis of the liver, complications of pregnancy, and homicide. The maternal death rate dropped from 9.0 in 1949 to 7.2 in 1950, a record low.

Death rates for influenza and pneumonia for 1950 increased slightly over 1949, probably as a result of the influenza epidemic during the late winter and early spring months of 1950. The death rate for diseases of the heart also increased slightly, while the rate for cancer remained at about the same level in both years.

General Interest

CALENDAR OF MEETINGS

Notices to be published in this Calendar should be sent to THE JOURNAL at least two months in advance of the date of the event.

GEORGIA CHAPTER OF AMERICAN ACADEMY OF GENERAL PRACTICE, Idle Hour Country Club, Macon, October 25. Dr. Walter W. Daniel, 743 West Peachtree St., N. E., Atlanta, President.

SOUTHERN MEDICAL ASSOCIATION, Dallas, Tex., November 5-8. Dr. C. P. Loran, Empire Building, Birmingham 3, Ala., Secretary-Manager.

AMERICAN COLLEGE OF SURGEONS 37th CLINICAL CONGRESS, San Francisco, Calif., November 5-9. Dr. Paul Hawley, 40 East Erie St., Chicago 11, Ill., Director.

THE SOUTHERN SECTION OF THE AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, INC., Academy of Medicine, Atlanta, January 14, 1952. Dr. Lester A. Brown, Atlanta, Vice-President.

DISTRICT AND COUNTY SOCIETIES

NOVEMBER 15—Fifth District Medical Society, Atlanta. Dr. L. Minor Blackford, Secretary.

DECEMBER 5—Sixth District Medical Society, Macon, 2 p. m. Dr. Charles H. Richardson, Jr., Secretary.

DECEMBER FIRST WEEK—First District Society, Statesboro. Dr. William H. Fulmer, Secretary, Savannah.

DECEMBER FIRST WEEK—Fourth District Medical Society, Newnan. Dr. James N. Bryant, Jr., Secretary, Newnan.

The SECOND DISTRICT MEDICAL SOCIETY held its semi-annual meeting on October 4 in Thomasville. Those appearing on the scientific program were: Drs. David Henry Poer, Atlanta; Paul W. Lucas, Tifton; Fred E. Murphy, Thomasville, and Davis S. Mann, Albany. Also on the program were: Lt. C. H. Lindsey, State Selective Service Office, Atlanta, and Mr. Sid Wrightsman, Jr., Executive Secretary and Public Relations Director, Medical Association of Georgia, Atlanta. Officers of the Society are: Drs. C. K. Sharp, Arlington, president; Paul T. Russell, Albany, vice-president, and Frank A. Little, Thomasville, secretary-treasurer. Drs. C. K. Wall, and Charles H. Watt, both of Thomasville, the Society's counselor and vice-counselor, respectively.

The SEVENTH DISTRICT MEDICAL SOCIETY met on September 26 in Cedartown, and was entertained that evening at a barbecue given by the Polk County Medical Society. Scientific papers were given by Drs. Lee H. Battle, Jr., Rome; Edward Bosworth, Rome; W. D. Hall, Calhoun, and Dixon Fowler, Atlanta. The group was welcomed to Cedartown by Dr. R. O. Chaudron. Officers of the Society are: Drs. Ralph Fowler, Marietta, president; A. B. Kitchens, LaFayette, vice-president, and R. D. Walter, Calhoun, secretary-treasurer. Dr. W. C. Mitchell, Smyrna, was appointed as a member of the subcommittee on public health of the Medical Association of Georgia from the Seventh District.

The BIBB COUNTY MEDICAL SOCIETY met in Macon on September 4, and heard an address by Dr. Rufus Payne, head of Battey State Hospital, Rome, on "Diagnosis of Tuberculosis."

The WARE COUNTY MEDICAL SOCIETY met in Waycross on September 6, with Drs. Harold W. Muecke and C. M. Massey as hosts. The group witnessed a showing of the film "Diagnosis of Poliomyelitis." Dr. Ansley Seaman and Dr. Muecke were appointed to the advisory committee of the Ware County Polio Committee. Attending the meeting as a guest was Dr. J. F. Hooker, new medical director of the Regional Health Office in Waycross.

The NINTH DISTRICT MEDICAL SOCIETY held its semi-annual meeting in Jasper on September 26. Scientific papers were read by Drs. Grady Coker, Canton; Augustus McCravey, Chattanooga, Tenn., and W. F. Reavis, Waycross. The District Women's Auxiliary met at the same time. Officers of the Ninth District Society are: Drs. E. A. Roper, Jasper, president; P. T. Scoggins, Commerce, vice-president; Hartwell Joiner, Gainesville, secretary-treasurer; W. Bruce Schaefer, Toccoa, counselor, and Charles R. Andrews, Jr., Canton, vice-counselor. Committee members: Dr. Hartwell Joiner, Gainesville, Public Relations; Dr. Marcus Mashburn, Sr., Cumming, Legislation, and Dr. Robert T. Jones, III, Canton, Public Health.

The FOURTH DISTRICT MEDICAL SOCIETY held its regular quarterly (repeat quarterly), meeting in LaGrange on Tuesday, September 25. Dr. W. F. Reavis, Waycross, President of the Association, was present and discussed activities and plans for the future.

DR. W. K. PHILPOT, Augusta, Secretary-Treasurer, RICHMOND COUNTY MEDICAL SOCIETY, an-

nounced at a recent meeting of the Board of Governors the following members were appointed to serve on the Medical Advisory Committee as proposed by the Medical Foundation for Infantile Paralysis: Dr. Abe J. Davis, Chairman; Dr. J. L. Chandler; Dr. R. C. McGahee; Dr. J. D. Gray, and Dr. John M. Martin, all of Augusta.

Doctors, dentists, druggists, and their wives from Winder, Commerce, Jefferson, and Athens attended the barbecue given by the JACKSON-BARROW MEDICAL SOCIETY in Commerce.

Those from Winder reported in attendance included Dr. and Mrs. Alex Russell, Dr. and Mrs. W. T. Randolph, Dr. and Mrs. T. S. Saxon, Dr. and Mrs. Ed Etheridge, Dr. and Mrs. R. D. Weaver, Dr. and Mrs. William Barron, and Dr. and Mrs. Haase Arnold.

ANNOUNCEMENTS

"The Editor and His Responsibility to the Community for the Improvement of Medical Service" will be the theme of the *Second Annual Medical Press and Radio Conference* of the Medical Association of Georgia, to be held on Friday evening, October 26, at the Dempsey Hotel, Macon.

Main speakers at the Conference will be Leo Brown, Public Relations Director, American Medical Association, Chicago, and Dean Raymond B. Nixon, Emory University School of Journalism, Atlanta.

Official functionaries of the Medical Association of Georgia at the Conference will be Dr. Stephen T. Brown, Presiding Officer, and Dr. Allen Bunce, Toastmaster, both of Atlanta, and Dr. A. M. Phillips, Moderator, Macon.

An open forum discussion will follow dinner, panel members of which will include Ben Chatfield, Radio Station WMAZ, Macon; Roy F. Zess, Radio Station WMGA, Moultrie; Joe Parham, Editor, *Macon News*, Macon; Miss Dana Hudson, President, Georgia Nurses Association, Atlanta; Mrs. J. R. S. Mays, President, Woman's Auxiliary to the Medical Association of Georgia, Macon, and Drs. Stephen T. Brown, W. S. Dorough, C. C. Aven, and Allen Bunce, all of Atlanta.

Under the auspices of the Medical Association of Georgia, the annual press and radio conference is based on the recognition of the fact that the public is entitled to news on medical and health matters and, therefore, it is in the public interest that news disseminating agencies and physicians provide such news promptly and accurately.

All members of the Medical Association of Georgia are invited to attend and reservations should be made in advance by contacting the public relations office of the Association, 875 West Peachtree Street, N. E., Atlanta.

The JONTE EQUEN MEMORIAL LECTURESHIP will be delivered by Dr. Louis H. Clerf, Professor of Broncho-Esophagology, Jefferson Medical College, Philadelphia, "Carcinoma of the Air Passages", at the Academy of Medicine, Atlanta, on November 29 at 8 p. m. Refreshments will be served after the lecture.

Georgia physicians appearing on the program at the Forty-Fifth Annual Meeting of the SOUTHERN MEDICAL ASSOCIATION held in Dallas, Tex., November 5-8: Drs. H. E. Nieburgs, E. R. Pund, Robert B. Greenblatt, Wm. E. Barfield, David A. Davis, Stephen W. Brown, all of Augusta; Drs. Olin S. Cofer, Councilor; James R. Garner, David James, James H. Semans, Montague L. Boyd, Edgar Boling, Morgan B. Raiford, H. Stephen Weens, Osler A. Abbott, John S. Atwater, Howard Hailey, J. Hiram Kite, George A. Williams, A. S. Velkoff, Harold P. McDonald, T. F. Sellers, all of Atlanta; Dr. Robert C. Pendergrass, Americus; Drs. C. E. Irwin and Ralph W. Coonrad, Warm Springs; Dr. John J. Brennan, Camp Gordan, and Dr. A. M. Phillips, Macon.

The annual dinner party of the EMORY CLUB OF SOUTHERN MEDICAL ASSOCIATION will be held on Tuesday, November 6, at 7 p.m., in Banquet Room Number 1 at the Baker Hotel, Dallas, Tex. Club officers are: Drs. Robert C. Pendergrass, Americus, president; Leonard T. Furlow, St. Louis, Mo., vice-president, and Edgar M. Dunstan, Atlanta, secretary-treasurer.

The MEDICAL COLLEGE OF GEORGIA announces its second symposium on exfoliative cytology, cancer detection and diagnosis, to be held December 9-11, 9-14 and 9-21 under the direction of Dr. H. E. Nieburgs, Director, Department of Clinical Cytology, and his staff. The symposium will provide a concentrated program of teaching on the fundamentals of cancer, cytology and diagnostic procedures. Those attending may come for three days, six days or a full two weeks. In addition to the faculty of the Medical College, 14 guest lecturers from medical schools, hospitals and institutes in many states will appear on the program.

The fifth annual meeting of the SOUTHEASTERN STATES CANCER SEMINAR will be held on November 28-30, in the San Juan Hotel, Orlando, Fla. The faculty will include Drs. Vincent P. Collins, Alfred Gellhorn, Cushman D. Haagenzen, Perry B. Hudson, Herbert B. Maier, Joseph J. McDonald, Milton R. Porter, Arthur P. Stout and Gray H. Twombly, from the staff of the Francis Delafield Hospital, New York City.

The SOUTHEASTERN REGIONAL meeting of the AMERICAN COLLEGE OF PHYSICIANS will be held at Georgia Washington Hotel, Jacksonville, Fla., Friday and Saturday, November 2 and 3. There



RED CROSS CHAIRMAN SHOWS THE WAY

Dr. Irving Greenberg and wife (Dr. Regina Gabler) donate blood to Atlanta Red Cross Center

will be 18 scientific presentations of interest to all. Also several guest speakers of note. All Fellows and Associates of the College in the State of Georgia are urged to attend. All physicians who are members of the Medical Association of Georgia are cordially invited.

A special course of instruction in HOSPITAL ADMINISTRATION is being arranged at the Atlanta Division of the University of Georgia by Dr. R. C. Williams, Director of Hospital Division, Georgia Department of Public Health.

CORRESPONDENCE

HEADQUARTERS SIXTH NAVAL DISTRICT
NAVAL BASE, S. C.

21 September 1951

To The Editor:

The purpose of this letter is to acquaint you with the present procedures whereby eligible civilian physicians may request an appointment in the Regular Navy, and to solicit your cooperation in an effort to secure wide publicity of this matter in the State of Georgia.

Civilian physicians with no present service affiliation and who did NOT participate in the

Army Specialized Training Program (ASTP) desiring commissions in the Regular Navy should apply to the Office of Naval Officer Procurement, Post Office Building, Macon, Georgia.

It is no longer necessary for the young physician to be ordered to appear for written professional examination and to await action thereon before appointment may be effected. Those serving in internship may submit their applications within two months of completion date, but appointments will not be issued until they have satisfactorily completed internship.

Your interest and cooperation in this matter are appreciated.

Sincerely,
J. B. LOGUE,
Rear Admiral (MC) USN
District Medical Officer.

Sept. 26, 1951.

To The Editor:

Recently we had the misfortune of losing our Doctor, Dr. A. H. Beazley, here in Crawfordville, Ga. The Dean of the Medical School in Augusta suggested that I contact you and have you run a notice in the State Medical Journal of our need.

Crawfordville is a town of 1000 population,

the county seat, and within 20 miles of two excellent hospitals. There is no other Doctor in town or in the county. Dr. Beazley left a nice office and equipment that would be available if wanted.

Your cooperation will be appreciated.

Yours truly,
EMILE WILLIAMS.

Sept. 21, 1951

To the Editor:

We are badly in need of a physician in Buchanan, which is a town in the rural section of Northwest Georgia.

Anyone interested in this location, please get in touch with me.

Sincerely,
H. G. RICHARDSON, Cashier
Haralson County Bank
Buchanan, Ga.

Atlanta, Ga., Oct. 1, 1951

Editor The Journal:

In my article on the history of the medical colleges of Atlanta, the name of Dr. L. B. Clarke as Professor of Pediatrics in the Atlanta School of Medicine was inadvertently omitted.

Dr. Clarke was father of Dr. M. L. B. Clarke, of the Fulton County Medical Society.

Yours very truly,
F. K. BOLAND, M.D.

PERSONALS

Transition

DR. JANET ALEXANDER—for 21 years a medical missionary in Pakistan, is the new college physician and professor of physical education at Agnes Scott College, Decatur.

DR. RAFE BANKS, JR.—for the past four years member of house staff of Grady Memorial Hospital, Atlanta, opened offices, 111 N. Main St., Gainesville. Urology.

DR. E. D. BELL—formerly intern in Norfolk (Va.) General Hospital, opened office in Douglas.

DR. NAPIER BURSON, JR.—announces removal of his offices to 1083 West Peachtree St., N. E., Atlanta. Internal medicine and gastroenterology.

DR. FLOYD COSLETT—moved from Battey Hospital, Rome, to 907 Northeast 15th Ave., Fort Lauderdale, Fla.

DR. JOHN K. DAVIDSON, III—opened office, 300 Martin Building, Columbus. Internal medicine.

DRS. HAL M. DAVISON, C. RAYMOND ARP, JOHN S. ATWATER and LAMAR B. PEACOCK—announce their association for the practice of internal medicine, Suite 207, Doctors Building, Atlanta.

DR. MAYES GOBER, Marietta—formerly surgeon and obstetrician, announces he will restrict his practice to obstetrics.

DRS. C. STEDMAN GLISSON, JR., and ARTHUR A. SMITH—announce removal of their offices to 1102 West Peachtree St., N. W., Atlanta. Gynecology and obstetrics.

DR. MARVIN L. GREENE—formerly of staff of Charity Hospital, New Orleans, La., opened offices in Monticello.

DR. IRVING HALL—formerly intern at Charity Hospital, New Orleans, La., is living in Clarkesville and assisting physicians there.

DR. MILFORD HATCHER, Macon surgeon, and his associate, DR. JAMES CALDWELL, plan to move in about three months into the new one-story 18-room office building which is being built for them on Spring Street. Dr. Caldwell recently came to Macon from the University of Michigan, where he was a member of the medical school faculty.

DR. T. L. HODGES, JR.—formerly of Decatur, re-established his office in Forsyth following his release from the Navy.

DR. W. P. JORDAN, JR.—formerly of Columbus, opened office at 502 G St., Brunswick. Urology.

DR. E. J. MAXWELL, JR.—formerly director of health at University of Georgia, Athens, opened offices, 719 Jackson St., Thomson. General surgery.

DR. JULIAN NEEL—formerly of staff of Charlotte (N. C.) Memorial Hospital, opened office, 207 East Jackson St., Thomasville. General surgery.

DR. WILLIAM LAWRENCE SALTER—formerly of Hampton, S. C., opened office, 2427 Abercorn St., Savannah. General.

DR. CHARLES P. YARN, JR.—associated with Drs. William G. Hamm and Frank F. Kanthak, Suite 1101, Medical Arts Building, Atlanta. Plastic and reconstructive surgery.

Helpmeets

DR. ALFRED HINTON HUNT, Atlanta and Camak, and Miss Patricia Ann Wheeler, Augusta—married October 1 in Augusta.

Miss ANNA THURMAN, Atlanta, and Mr. G. E. Finch, Jacksonville Beach, Fla. and Atlanta—married October 6 in Atlanta. Mrs. Finch for the past 30 years has been a member of the staff of the Emory University School of Medicine.

For Your Admiration

TO MR. AND MRS. SID WRIGHTSMAN, JR.,

Atlanta, a daughter, Jean Anne, on September 27. Mr. Wrightsman is executive secretary of the Medical Association of Georgia.

DEATHS

BARNETT: *Dr. James Miller Barnett*, 72, of Albany, died suddenly September 12 of a heart condition. The general practitioner, nationally known for his work in malaria, was in his 50th year of practice. A 1902 graduate of the Emory University School of Medicine, Dr. Barnett did postgraduate work at New York City Postgraduate School and Hospital, Mayo Clinic, Rockefeller Institute, Walter Reed Hospital, Harvard. In private practice in Albany since 1914. For 36 years medical member of Dougherty County Board of Health, and had never missed a board meeting in that time. Captain in Army Medical Corps in World War I, fellow of the American College of Surgeons, author of numerous scientific papers.

JOHNSON: *Dr. Raymond Johnson*, of Waycross, who was born in 1881, died on September 1. He had been officially retired for 10 years, but still occasionally treated former patients who asked him to. Was graduated in 1914 from University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore.

WINN: *Dr. John H. Winn*, 63, of Columbus, eye-ear-nose-throat specialist, died September 17 after a six-month illness. Born in Canada, served as an officer in World War I. Was graduated from Tennessee College of Medicine, Memphis; took postgraduate work at New York School of Eye, Ear, Nose and Throat, Tulane, and University of Chicago. He had practiced in Columbus 30 years.

MISCELLANY

One hundred and 60 doctors registered for the third annual meeting of the GEORGIA HEART ASSOCIATION, which was held at the General Oglethorpe Hotel in Savannah on September 14-15.

Chosen by the Association as its officers for the next year were: Dr. Harry T. Harper, Jr., Augusta, president; Dr. Thomas L. Ross, Jr., Macon, president-elect; Dr. Ellison R. Cook, Savannah, vice-president; Dr. J. Willis Hurst, Atlanta, secretary and James D. Robinson, Jr., Atlanta, treasurer.

Named to serve three-year terms on the Association's Board of Directors were five physicians and three laymen, as follows: Dr. Emmett Brannen, Rome; Dr. Arthur Knight, Waycross; Dr. R. Bruce Logue, Atlanta; Dr. Thomas McGoldrick, Jr., Savannah; Dr. Ernest F. Wahl, Thomasville; Herbert Haley, Albany; William T. Johnson, Dalton, and William S. O'Neal, Douglasville.

Dr. Martin Cherkasky, of Montefiore Hospital, New York, spoke at the joint session on "Community Organization in a Heart Disease Program." Speaking also was Dr. Walter Sheldon, Pathologist, of the Emory University School of Medicine.

The scientific sessions presented two papers by each of the following guest speakers: Dr. Louis N. Katz, director of cardiovascular research, Michael Reese Hospital, Chicago; Dr. Herrman L. Blumgart, professor of medicine, Harvard Medical School; Dr. Edward Weiss, professor of clinical medicine, Temple University School of Medicine, and Dr. Thomas N. Durant, also professor of clinical medicine at Temple.

DR. ALBERT M. DEAL, Statesboro, has been appointed by Gov. Herman Talmadge to succeed DR. PHIL ROBERSON, Albany, as a member of the State Board of Medical Examiners. At the same time Dr. Steve Kenyon, Dawson, was reappointed to the board.

DRS. MURDOCK EQUEN and ROBERT BROWN, Atlanta, presented a course on "Magnetic Removal of Foreign Bodies" at the meeting of the Academy of Ophthalmology and Otolaryngology in Chicago October 14-19.

Two Atlanta doctors—DR. WILLIAM GALVIN, of the Emory University School of Medicine, and DR. EDGAR BOLING—presented scientific papers before the Piedmont Proctologic Society at its recent meeting in Asheville, N. C.

MISS MARGARET LAFEVRE, coordinator, Cerebral Palsy Center, Savannah, and eight other outstanding authorities participated in the seminars of the annual convention of the National Society for Crippled Children and Adults in Chicago, October 3-5.

DR. FLOYD W. MORGAN, Douglasville physician, recently appeared in the "Picture Parade of Prominent People" which is published in the *Douglas County Sentinel*.

On October 11 the STATE BOARD OF HEALTH held its regular fall meeting in Atlanta in conjunction with the new Committees and Subcommittees on Public Health of the Association. During the day all department heads of the Georgia Department of Public Health presented short discussions of its activities and plans for the future. The development of the civil defense program in the State was also discussed by Dr. Edgar M. Dunstan, Atlanta, Chairman.

More than three per cent of the nation's drivers are young folks who have received special courses in their schools to help insure safety on the road when they take the wheel of the family car. These safety-trained young drivers

have only one-third as many accidents as untrained students.

Drastic measures to control the spread of polio in that area were taken in the late summer and early fall by Elbert County physicians, public health officials, and the mayor and council of Elberton.

Churches and other meeting places were closed, and the openings of schools and of the Elbert County Fair were postponed. Every home and business house in Elberton and surrounding communities was sprayed. Ordinances and state laws concerning open privies, hog pens, open garbage dumps and garbage cans, and the like were strictly enforced. Public gatherings were discouraged.

In support of the concerted effort advertisements were run in the *Elberton Star* by the Elbert County Medical Society, the mayor and council, and the chief of police.

The Georgia Chapter of the American College of Surgeons sponsored a joint meeting with the Georgia Urological Association, Georgia Society of Anaesthesiologists, and the Georgia State Obstetrical and Gynecological Society in Augusta on October 18. The Georgia Radiological Society was invited to hold its regular fall session with these surgical groups.

During the day the following guest speakers participated in clinical discussions and informal talks:

Dr. John A. Adriani, New Orleans; Dr. Wm. A. Boyd, Columbia; Dr. Ralph M. Caulk, Washington; Dr. G. J. Curry, Flint, Michigan; Dr. Harry Winkler, Charlotte, N. C.; Dr. Elmer U. Hess, President, American Urological Association, Erie, Pa.; Dr. Julian Johnson, Philadelphia; Dr. Alton Ochsner, New Orleans, President-Elect, American College of Surgeons; Dr. Ronald Stephens, Durham, N. C.; Dr. J. D. Guess, Greenville.

At noon Dr. Alton Ochsner, President-Elect of the American College of Surgeons discussed activities of that organization and Dr. H. Prather Saunders, Associate Director, president the Georgia Chapter with its charter, Number Six in the United States.

The evening session was sponsored by the Richmond County Medical Society with Dr. Thomas W. Goodwin, President, presiding.

THE SOUTHERN REGIONAL EDUCATION PROGRAM announces that the Committee on Nursing Education held its first meeting October 9-10 at the Board headquarters in Atlanta. This committee is made up of 17 men and women who are educators, nursing specialists, members of state boards, and hospital administrators. It sought the answers to such questions as these: How many nurses does the South actually need? What is the shortage today, and how many should be graduated each year to meet con-

tinuing needs? What are the educational facilities in the South for training nurses? How far apart is the need for nurses and the number being trained?

After the committee gets the facts established, it will have the responsibility of recommending steps to improve the training and increase the number of nurses.

The result is expected to be the nation's first program joining the forces of the nursing and medical profession, the states and the educational institutions across a wide region. Miss Dant Hudson, Georgia Baptist Hospital, Atlanta, will represent the nursing profession in Georgia.

HOSPITAL NEWS

THE McDUFFIE COUNTY HOSPITAL, Thomson, is staffed by all physicians and dentists of McDuffie County. At a recent meeting called by William H. Cox, hospital administrator, Dr. F. N. Gibson was chosen president of the staff, and Dr. Albert G. LeRoy, secretary. Attending the meeting were Dr. Gibson, Dr. LeRoy, Dr. F. B. Riley, Jr., Dr. Edgar J. Maxwell, Jr., Athens (who plans to move to Thomson), Dr. Tom Neal, and E. C. Hawes and Lawrence Knox, members of the McDuffie County Hospital Board.

The ASKEW MEMORIAL HOSPITAL in Nashville, closed since last January, was reopened in September by Drs. W. W. Turner and J. D. Turner. The hospital was shut when Dr. W. W. Turner moved to Jamestown, N. C., to practice; he returned to Nashville in July. Five nurses are on duty in the 15-bed hospital. Dr. W. W. Turner announced a plan to open the hospital at an early date to all Nashville and Berrien County physicians, to enlarge the nursing staff, and to erect an annex which will increase the bed capacity of the hospital to 25.

In order to make way for the anticipated expansion of the Macon Hospital, the City of Macon since 1948 has purchased 17 houses in the neighborhood at a cost of more than \$106,000, Mayor Lewis Wilson says. In no case was one of the houses condemned, and in several instances the city purchased property elsewhere suitable to the owner and swapped it to him for his old property, the mayor states.

With the aid of Hill-Burton funds, the city hopes to enlarge the Macon Hospital into a 550-bed institution. The entire area around that hospital is developing into a medical center. Adjacent or nearby are the Middle Georgia Hospital, the Medical Arts Building, the Macon-Bibb-Jones County Health office, the Central Regional Office of the State Department of Public Health, and several new buildings housing doctors' offices.

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Editorials

"The reality of human nature is bound to elude us if we look only at a momentary cross section of it."—WALTER LIPPMANN.

DIABETES DETECTION WEEK

The easily recognized symptoms of the severe diabetic have been recorded in the pages of history from ancient times. The weakness, fatigue, and abnormal hunger of a diabetic sufferer has been recognized for centuries, but it is only within the past generation that science has been able to penetrate the surface of this mysterious condition, which hitherto has almost invariably ended fatally. This achievement of medical science in conquering diabetes places the conquest among the most notable medical triumphs of history. Although the underlying causes of this condition are still not thoroughly understood, each year adds a vast amount of research which supplies pieces of a jig-saw that may in time permit us to see the whole picture of diabetes and its many complications.

Diabetes was twenty-seventh among the causes of death in 1900. By 1945 it had come to be eighth among diseases as a cause of death. The increase was unquestionably due, for the most part, to the fact that many diabetics were not found until the disease was far advanced. The earlier it is discovered, the easier it is to control and the

more normal and effective the life of a diabetic can be.

Now that we have materials at hand with which to control this condition it remains for us to seek out those who may be suffering from it unbeknown to themselves. A great many diabetics have not yet developed symptoms severe enough to warrant their being conscious of the disease. Diabetes, which may be slow in onset, may not cause acute symptoms, or such symptoms as may be present can be so mild that a diabetic condition is not considered.

It has been estimated that for every known diabetic in this country there is one unknown diabetic suffering from the condition in a moderate to severe form. Added to these are a great many borderline and potential diabetics who should be found and watched carefully lest they too might develop a severe condition. Untreated diabetes may be a very costly chronic illness, both to the individuals involved and to the businesses and industries in which they work. A person suffering from an undiagnosed case of diabetes may likely be habitually unwell. Efficiency is greatly reduced,

and frequently such a person may be unable to work at all.

A few years ago a national organization composed mainly of physicians and known as the American Diabetes Association began the tremendous task of searching out these unknown, undiagnosed, and unsuspected diabetics. For the past three years the American Diabetes Association has sponsored and helped to organize a nationwide Diabetes Detection Drive. This drive is directed by the medical profession working through local medical societies, usually in cooperation with public spirited lay groups in each community. Each year in the fall a Diabetes Detection Week is proclaimed, and during this time an intensified screening program is undertaken in many localities to search for diabetics. All medical societies which have means of cooperating with the American Diabetes Association encourage every person in the community to make every effort to have his personal physician, a testing center, or a teaching center for self testing, do a test for diabetes. The undiagnosed case of diabetes should be brought to light before it has a chance to become more serious and harder to control.

Last year materials for over 1,500,000 urine tests were distributed by the American Diabetes Association to hundreds of cities and towns co-operating in the program. In these communities special Committees on Diabetes offered free tests to all comers, both in doctors' offices and in specially organized testing centers.

A great many states reported that the 1950 campaign showed a considerable increase in effectiveness over previous years. In Connecticut there was an increase of 63 per cent more specimens examined than the previous year's total. This report stated that more than 500 positive urine specimens were found, more than half of which came from people who were not previously known to be diabetic.

During the week of Dec. 6, 1948, 69,159 persons were tested in Dayton, Ohio. Glycosuria was found in 2,991, or an incidence of 4.3 per cent. Sugar determinations revealed 151 known diabetics and 148 new diabetic patients. At the same time in St. Louis, 17,451 urines were examined, with glycosuria being found in 3.46 per cent. Of these 143 were known diabetics and new cases were found in 162. Twenty-six cases were listed as probable but not proved. Seventy-five per cent of these people with hyperglycemia were found to be overweight. In last year's campaign approximately 7,500 hidden diabetics were found throughout the country.

Statistics at the present time seem to indicate that there is an incidence of slightly more than two per cent of diabetics discovered in these case finding surveys. The great majority of these individuals are still unaware of their diabetic condition. Today the diabetic whose disease is being treated need have very little discomfort and still less fear.

Intelligent cooperation with his physician as to treatment, diet, and pattern of living will permit a diabetic to live long, usefully, and happily, and lead a life as normal in most respects as other people. Most diabetics whose condition is known and who are under medical care can continue with their normal occupations. Only in a few cases may it prove necessary to shift a diabetic to less hazardous tasks. In almost every case the known diabetic can remain a useful member of society and not become a charge against his family, his employer, or the state. A diabetic under treatment may even be said to expect better health than average since his physician will be aware of possible complications of all sorts, and will be on the lookout for them, and thus may prevent many complications and ravages oftentimes from becoming too serious. The uncontrolled diabetic, or the one who does not take care of his disease, may soon become a victim of diabetic coma, gangrene, hardening of the arteries, or failing eyesight.

In Georgia we have had to decide whether or not a concentrated Diabetes Detection Drive lasting one week would be a sufficient and satisfactory means of doing as much as we could to discover new diabetics. The late Dr. James E. Paullin was one of the first to realize that it took a great deal of experience to conduct a large survey, and so he enlisted the aid of the Georgia Department of Public Health. This department had been doing mass surveys for tuberculosis and syphilis since 1942 and their knowledge and experience were invaluable.

Detection campaigns of any nature have many drawbacks. At best they can touch only a small segment of the population of a state or country as a whole. Various methods of testing are necessary and not all are satisfactory in all ways. Too many people are overly anxious to play doctor to themselves and others, and to put into their hands such things as Clinitest tablets for self testing is certainly not too wise. The repercussions that could result if a child should be burned by putting a Clinitest tablet in his mouth could jeopardize the entire campaign. Too often, too, a negative test for sugar in the urine may give a patient a false sense of security.

We, in Georgia, may consider ourselves fortunate

Highly gratifying has been the response by the press of Georgia to the plan proposed in the September issue of THE JOURNAL for improving the care and treatment of the sick at the State Mental Hospital in Milledgeville. Headings from some of the news stories and editorials carried by daily and weekly newspapers of the state are shown at right.



Doctors Seek Kinder Mental Patient Treatment
 Mental Patient Treatment
 ic Asked
 Atlanta
 Better Care of the Insane
 IS THE TIME FOR ACTION
 Medical Association Urges 5-Point Plan
 Methods of Handling 'Crazy People'
 At Milledgeville
 Medical Journal Outlines Plan
 Improve Care of Insane
 Improvements For Georgia's Mental Hospital
 Jaycees Urge Expenditures To Correct State Hospital
 This is a Program All Should Support
 Medical Association Sets Program For State's Milledgeville Hospital
 Doctors Journal Urges Modernization Of Methods of Handling 'Crazy People'
 Outline Plan For Improving Care Insane In Georgia
 Georgia Physicians Propose Program For Milledgeville Hospital Improvement
 Medical Journal Maps Plan On Care Of MSH Patients
 Steps to Correct Care of Mental Patients Sought
 Five-Point Plan
 Georgia Medical Group Deplores Mental Set-Up
 The Problem of Mental Illness
 Screen Center For Mental Ill
 Alverson Backs

nate, therefore, to know that our State Department of Public Health is conducting a year-round search for the unknown diabetics. If the incidence rate is a little over two per cent, or 20 diabetics per thousand individuals, these figures when applied to the total population of Georgia mean that we might expect to find over 60,000 people with diabetes in our state.

To care for these new diabetic patients who are going to be referred to the private physician, it behooves every physician to know what must be done to help these individuals. The orthopedist, the gynecologist, or the otolaryngologist should

know the men in the community who can help these patients. Every internist or general practitioner should see that facilities are available to recheck the abnormal blood sugar findings reported by the survey, and determine the cause of the abnormality. No diagnosis of any kind is made by the screening center. Only an abnormality of carbohydrate metabolism is reported. It is up to the physician to make the diagnosis and then proceed with the proper treatment. Doctor, are you prepared to assist one of these unknown diabetics, should he come to you for help?

CHRISTOPHER J. McLOUGHLIN, M.D.

IV. OUR TWENTY-FIVE DOLLARS

JUDICIAL COUNCIL

The Principles of Medical Ethics of the American Medical Association are the "Bill of Rights" of the medical profession. They are fundamental to the high professional standards which characterize medical practice today. They have withstood many bitter attacks.

The Judicial Council is the Supreme Court of American medicine. They decide on all questions of an ethical or judicial character that may arise in connection with the Association, its constituent societies and all members. *The Council concerns itself with the questions of law and procedure but not of fact.*

These ethical standards which have been maintained and defended by the medical profession and have been so wisely interpreted by the Judicial Council against many odds, still remain the greatest safeguard to our health. Let every physician who cares for the future of his profession continue to cherish these traditions.

BUREAU OF LEGAL MEDICINE AND LEGISLATION

This Bureau was established in 1922 and has a wider field of usefulness than is expressed in its title. It performs a vital function to the profession and to the public. Thousands of bills concerning health are introduced in state and national legislatures every year. Some of these bills are good but often need rewording for clarification. Many, if enacted into law, would be a detriment to the health of the people. This Bureau tabulates these bills and gathers information on them. This information is assembled and is then published in the *Journal*. This information is available to those interested in such matters on request.

The Bureau gathers information on a wide variety of subjects such as partnership agreements, income tax problems, expert testimony, constitution and by-laws, basic science laws, birth control laws, and many other medico-legal topics. *It is not in a position to give legal advice to physicians on specific problems of purely personal nature.*

WASHINGTON OFFICE

For many years the House of Delegates, through a small committee, tried to keep up with national legislation dealing with health and medical practice. The task became so great that the House of Delegates, in 1942, decided to open an office in Washington whose primary function would be that of information on health legislation. This information would be available to anyone who desired it. In 1944 Dr. Joseph S. Lawrence, Executive Secretary of the New York State Medical Society, was appointed its first director. The supervision of this office is directly under the Board of Trustees, who in turn report to the House of Delegates. In 1949 a deputy director, Dr. Frank E. Wilson, and a legal adviser, Mr. James W. Forestel, were added. In 1950 Dr. Cyrus Maxwell joined the staff as assistant director. Today there are nineteen full and part time employees.

The Washington office is responsible for collecting and distributing information concerning federal legislation and the activities of federal departments of interest to the medical profession. It is an instrument through which official opinions and views of the A.M.A., are made known to Congress. The 81st Congress had over 15000 bills presented. This office closely followed and reported on 425 of these bills, which concerned health and the practice of medicine.

Other services include: (1) Furnishing individual Senators and Congressmen information and material for speeches, interviews, discussion and questions. Ewing and the Federal Security Agency are two of the most frequent users; (2) Furnishing speakers for professional and lay groups; (3) The furnishing of bills, reports, laws and government publications to members and non-members of the Association. Anyone, friend or foe, can get authentic information on medical matters from this office. Through its many contacts this office acquires factual information of importance to the medical profession.

The information and doings of the Washington office are passed along to the members through

three separate channels. They write the Washington News section for the Journal of the A.M.A. They write, edit, and print the Bulletin weekly in the office. They report on the introduction of bills and action of the National Legislature. The Capitol Clinic is published weekly and analyzes the news and reports covering the Washington scene of medical interest including national personalities. The mailing list of these last two publications has reached the 7,000 mark.

If you desire information on any legislative matter in Washington you can secure that information from this office. When in Washington take time to go around and visit this office. It is located at 1523 L St., N. W.

The Committee on Medicolegal Problems approved the publication of a report written by Louis J. Regan, M.D., LL.D. and printed in the J.A.M.A. of Sept. 1, 1951. Every physician should read the entire report. Below is a list of "Commandments" in malpractice prevention taken from this article.

A LIST OF "COMMANDMENTS" IN MALPRACTICE PREVENTION

"In the final analysis, it is the physician himself who is responsible for the continuing existence of the vicious malpractice situation. The physician has generally been satisfied to pay his professional liability insurance premiums and thereafter to sit back complacently, doing nothing until he becomes a target for a malpractice claim. He must be brought to realize that his money payment is only a part of his insurance premium; a much more important part is his contribution of time, of study, and of putting into effect all possible measures to safeguard himself and his colleagues.

Prevention is the best defense against malpractice. Listed below are the 23 malpractice prophylaxis "commandments:"

1. The physician should care for every patient with scrupulous attention to the requirements of good medical practice.

2. The physician must avoid destructive and unethical criticism of the work of other physicians.

3. The physician must know his legal duty to the patient.

4. The physician should keep "ideal" medical records in every case; records that would be presentable when offered in court; records that clearly show what was done and when it was done; records that clearly indicate that nothing was neglected and that the care given met fully the standard demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the record should show it; a good method is to file a carbon copy of the letter which advises the patient against the unwise course.

5. The physician should be careful to avoid making any statement which constitutes or which might be construed as an admission of fault on his part. Such an admission, which is usable against the physician, might be made to a third

party as well as to the patient at any time before the trial. Such an admission may be made by an agent or employee of the physician during the course and within the scope of the employment. It is important to instruct employees to make no statements.

6. The physician should exercise tact as well as professional ability in handling his patients. A proper professional manner and a sound attitude should be maintained at all times toward both the patient and the patient's family. The attentive physician may early sense some unsatisfactory and disturbing under-current which, by the institution of protective measures, may be prevented from developing into something much more unpleasant. Thus, if the patient is not doing well, consultation may be suggested; if the patient is dissatisfied or complaining, or if the family's attitude indicates dissatisfaction, consultation should be demanded. The use of a consultant affords, in any case, great protection against a malpractice claim.

7. The physician should refrain from over optimistic prognoses and should avoid promising too much to the patient.

8. The physician should advise his patients of any intended absence from practice and should recommend, or make available, a qualified substitute.

9. The physician should unfailingly secure written consent for operation and for autopsy.

10. The physician should carefully supervise assistants and employees and take great care in the delegation of duties to them.

11. The physician should have some knowledge of the statute of limitations and of its significance.

12. In his selection of patients the physician should limit himself to such fields as are well within his qualifications. He should keep abreast of progress in the medical profession.

13. The physician should keep inviolate all confidential communications.

14. The physician should frequently check the condition of his equipment and make use of every available safety installation.

15. In the treatment of the patient the physician must not experiment.

16. The physician must be careful to render sufficient care to his patient in general instructions, frequency of visits, clinical and roentgen ray laboratory investigations and the like. Moreover, every precaution should be instituted for the protection of those caring for the patient and of all other contacts.

17. The patient must not be abandoned. The physician-patient relation can be terminated without liability only in certain ways and under certain conditions.

18. The physician should never reveal that he carries professional liability insurance. Except on the recommendation of his legal adviser, he should never write a letter or make any statement with reference to a malpractice claim. Immediately on

being advised of even the possibility of suit, he should consult with his attorney.

19. The physician should arrive at an understanding in the matter of fees. Misunderstanding in this matter, particularly when the question of excessive fees arises, contributes an avoidable element of risk.

20. The physician should secure legal advice if he is called to attend a coroner's inquest as a witness in a case in which he has been in professional attendance.

21. The physician should realize that because of the possibility of error in transmission, it is dangerous to telephone a prescription.

22. The physician should realize that it is hazardous to sterilize any patient except when a medical indication exists.

23. Except in actual emergency, the physician should not examine a female patient unless a third person is present. There is no more serious or destructive charge than that of undue familiarity; and the only way to avoid claims of this sort seems to be to have some one else present during all examinations.

Dr. W. W. Bauer, Hempstead, N. Y., President-Elect of the A.M.A. says: "This is what you get

for your \$25—but wait. I should say this is what you might get for your \$25 if you only would. How many times have you traveled to Chicago without visiting A.M.A. headquarters in which you have so heavy an investment of interest and of money? How often have you referred a knotty problem in school health, in medical service, in medical economics or in the numerous scientific fields to the agency established by your representatives and financed by you? Have you supported by word of mouth the radio platter programs placed all over your state by your state medical society? Do you put TODAY'S HEALTH to work in your office, in schools, libraries and among your friends? On the basis of roughly twenty-five major activities at or closely related to A.M.A. headquarters they cost you each less than one dollar per year for direct services and for indirect benefits which can hardly be measured or evaluated.

"If you don't get \$25 worth for your membership check it may be due in part to the fact that you have never fully exercised your membership privileges. The resources are there. They wait only to be tapped."

EUSTACE A. ALLEN, M.D.

VA MAY USURP MALE POPULATION

The private practice of medicine today is threatened, and from a source far greater in scope and influence than Mr. Ewing and his Federal Security Agency.

That threat, no less, emanates from the Veterans Administration, through its acceptance for medical treatment of those with non-service connected disabilities.

On June 30, 1951, more than 60 per cent of veterans hospital patients were under treatment for non-service connected disabilities. (The actual figures totaled 103,369 patients, more than 66,000 of whom were receiving treatment for disabilities having no service connection).

Each of these 66,000 veterans ostensibly was a "pauper" in the VA's eyes, having obtained admission to a veterans hospital merely by declaring on a VA form, required by law, that he was unable to pay for medical care.

Few are unaware that the VA makes little, if any, effort to question or investigate the "pauper" declaration. A veteran, therefore, with but crossed fingers and few qualms, has unchallenged access to the nearest VA hospital at the taxpayers' expense and the private physician's loss.

American doctors unhesitatingly are behind the worthy veterans who, because of conditions traceable to their time in service, are entitled to medical and surgical care. But can the American medical profession continue to condone a law which knowingly classifies as "paupers" a majority of veterans who seek to qualify for VA treatment?

Consider the Veterans Administration: Its medi-

FROM PRIVATE MEDICAL PRACTICE

cal care program is one of the largest in the world, potentially affecting some 21 million veterans; it operates on a budget calling for expenditures in excess of \$650 million annually; it involves direct ownership and operation of 151 hospitals containing 119,400 authorized beds (more than 8 per cent of all hospital beds in the United States) and, if planners have their way, additional hospitals will be built containing more authorized beds.

With the Korean situation already in its second year, an increasing number of veterans each day are becoming eligible for government medical care. Furthermore, with the continued expansion of our Armed Forces and a better than even chance of Universal Military Training in the not-too-distant future, the potential veteran load is staggering to contemplate.

It is not inconceivable that, under the present veterans law, the Federal government will assume responsibility for the medical care of all males involved. Nor is it beyond the imagination that, within a few years, the Federal government will have usurped from the private practice of medicine the responsibility of providing medical care for more than 50 per cent of the male population of the United States.

The danger is obvious.

The existing veterans law must be changed to make the so-called "pauper" provision an honest requirement. And physicians owe it to themselves and to their profession to join in an effort to accomplish it.

THE GEORGIA INDUSTRIAL SURGEONS ASSOCIATION

In August, 1938 a group of physicians and surgeons interested in Industrial Medicine and Surgery formed the organization known as The Georgia Industrial Surgeons Association. The object and purpose of this group was to encourage (1) the advancement of the art and science of industrial medicine and surgery; (2) the improvement of mutual relations among all those interested in the physical care and financial aid of employees of industry who are suffering from industrial injuries and occupational diseases; (3) the fostering of fellowship and goodwill among those engaged in the specialized practice of industrial medicine and surgery. The membership consisted of those who were interested and engaged primarily in the practice of industrial medicine and surgery.

The first annual meeting was held at the Cloister

Hotel, Sea Island, November 5, 1938 with Dr. C. F. Holton of Savannah, the first president, presiding. Much credit is due Dr. Holton for his vision in recognizing the need for an organization of this type and for his talent and efforts in guiding it through its inception and the subsequent years. Annual meetings and programs were continued through September, 1941, and many outstanding leaders in the medical profession, workmen's compensation insurance and industrial boards participated. The programs were discontinued for the duration of the war and a few years afterward. However, a few business meetings were held. The Association has now been re-activated and will have its 1951 annual meeting on Saturday, December 8, at Atlanta. The program is being prepared and will be mailed to all members in the near future.

A. M. COLLINSWORTH, M. D.

FROM THE GEORGIA PRESS

Will the Doctor Come?

It's midnight, and your child is screaming with pain, running a temperature of 103. The panicky thought beat you to the telephone—can you possibly get a doctor to come to your house at that hour?

The answer, in Atlanta, today, is positively YES. But until about four months ago, you might have had trouble knowing how to get a doctor for a night emergency, if you were a newcomer to town and didn't have a family doctor to call. Now Atlanta is one of 300 cities that have a working system of taking care of all medical emergencies, day or night. The plan is sponsored by the Fulton County Medical Society, and was worked out by Dr. Chris J. McLoughlin, chairman of the committee on emergency medical service, with the help of Dr. Hal M. Davison, president of the Society.

In the yellow section of the telephone book, on Page 264, you will find two numbers—ATwood 5081 and ATwood 1666. If the first doesn't answer, call the second. Whichever you get, you will be supplied with the names of three doctors in your neighborhood who will cheerfully make night calls. . . . If all three are out, a repeat call to the above numbers will get you a few more names.—Wylly Folk St. John in the *Atlanta Journal-Constitution Magazine*.

The Cost of Hospitals Growing

One of the most amazing factors in our everyday life at this time is the increase in the number of hospitals and therefore hospital beds.

However there are two signally important phases that have been brought to the attention of the public. One is the increase in the costs of such services as the hospitals render. The

other is the rescue operations of insurance companies that now sell millions of hospitalization policies which are available to many more than ever before and are a guarantee to the poor man in case he is stricken or one of his family.

The cost of hospitalization is still cheap and available to almost anyone at a very nominal monthly fee. Hospitals are charging more so they can furnish all necessary facilities and pay fair wages and salaries. The combination makes it imperative that the patient take out insurance.

It is also evident that the hospitals with their enormous budgets and expenses must be supported as a public enterprise.

Doctors are now generally specialists and they have developed their diagnostic knowledge by the use of the various phases, most of which have been developed or promoted in the past thirty years. It is estimated that thirty per cent less patients now die than was the case only a few years ago and every community wants to be on the plan. This means that a part of the cost of many hospitals is paid out of public funds and it is proper that they should—not so much for charity work as for the highest type of services for all patients, whether type of services for all patients, whether poor or rich.—*Thomasville Times-Enterprise*.

Coffee Voluntary Way Starts

The Coffee Voluntary Way group hospital, surgical and medical insurance group will begin in Coffee County immediately. Each individual in the county will be contacted by the authorized enrollment officers. The Voluntary Way will feature the Georgia Plan, endorsed and sponsored by the Medical Association of Georgia.—*Coffee County Progress*.

President's Page

POSTGRADUATE MEDICAL EDUCATION

At the Interim Meeting of the AMA in Los Angeles during the week of December 4-7, the theme will be "Postgraduate Medical Education." In the past there has been much general discussion about this important problem but now the Association wishes to get down to brass tacks and do something about it.

What is the responsibility of the AMA and the Medical Association of Georgia to provide a continuing education for all physicians and its members in particular? Is it a duty of such organizations, or should the individual be stimulated to seek his own methods of improving his medical education at frequent enough intervals to insure his patients of the latest and most valuable methods of diagnosis and treatment?

In Georgia, the experience of the Association has been somewhat like forcing the mule to the trough, but up to now nobody has been able to make him drink. Many methods have been tried, including sending well-known medical teachers into all sections of the State, in teams and separately, but attendance has always been poor. Four of the outstanding heart specialists of the United States recently failed to bring out but a handful at a meeting in Savannah. At the present time the two medical schools offer courses directed to the general practitioner twice a year and in spite of the fact the Committee on Medical Education approves these courses and recommends their continuance (see report in this issue), the attendance of Georgia physicians at the last two sessions was extremely poor, and must be discouraging to the teachers and directors of the programs.

When experiences of other States is considered, one notes that large appropriations have been made by medical societies and also by private sources to carry on these programs, but again, the results are none too encouraging. What, then, is the reason that the average American physician resists so strongly these sincere attempts to give him valuable aid and assistance in performing his life work? Is it typical American individualism that brings the "mule" into action when someone attempts to use force, however tactfully presented, or is it just plain laziness and indifference?

However, the picture is not entirely dark in Georgia when one considers the success of the special groups, usually holding one-day meetings in one of our larger cities. Attendance at the Ma-



con meeting of general practitioners was 150 with a 25 per cent increase in membership. Over 200 attended the meeting of the Georgia Pediatric Society in Atlanta, and 300 surgeons were at Augusta on October 18 when several groups had nine guest speakers present at an intensive one-day program. Upon questioning, many physicians have indicated that they would prefer the medical colleges to arrange shorter courses of instruction with more emphasis on such basic studies as physiology, biochemistry and anatomy.

These are some of the questions that confront the officials of our Association in making decisions about the degree of participation by us.

We shall welcome suggestions by anyone. Mail these direct to the Secretary, Medical Association of Georgia, 875 West Peachtree Street, N. E., Atlanta.

W. F. REAVIS, M.D.
President

Scientific Articles

MEDICAL CONFERENCE AT EMORY UNIVERSITY HOSPITAL

The Clinical Approach to Congenital Heart Disease

Speaker: J. WILLIS HURST, M.D., Emory University Hospital, Atlanta

THE usual discussion of congenital heart disease entails the description of the cardinal features of the various defects. This morning I would like to alter this usual pattern of discussion and have you imagine that you have just been presented with a patient in whom congenital heart disease is suspected. What is your approach to the patient?

There are several tools at your command which can be used in your investigation of the patient. They are, in order of their performance, the history, physical exam, electrocardiography, laboratory studies, x-ray and fluoroscopy and on rare occasions cardiac catheterization. In the following discussion the information that can be obtained from each phase of the investigation will be discussed.

History: An inquiry should always be made regarding the mother's health during pregnancy. One should always ask if the mother had a virus infection, particularly German measles, during the first three months of pregnancy since it is not uncommon to have congenital heart disease, cataracts and deafness in the offspring of a mother who has had such an illness.

Inquire about congenital heart disease in other members of the family since in certain instances a hereditary tendency is apparent.

If a physician examined the child at birth you are interested in whether or not he commented on the presence of a murmur. The answer to this question may be helpful but is occasionally misleading since a normal systolic murmur may be heard at birth and later disappear or the murmur of congenital heart disease may be slight at birth and be classed as definitely abnormal later in life.

Was cyanosis present at birth? I am reluctant to completely accept a mother's opinion or observation of her child at birth. On

many occasions, even at an older age, the family does not detect obvious cyanosis. Even physicians may not be able to detect slight arterial oxygen unsaturation. Remember that cyanosis at birth is frequently the result of atelectasis and therefore does not necessarily indicate heart disease. Patients with interatrial septal defect may have slight cyanosis at birth and no cyanosis a few days later. On the other hand patients observed to have cyanosis at an older age may not have been obviously cyanotic at birth. If the patient has been definitely cyanotic since birth and is over the age of four or five Tetralogy of Fallot is the likely defect since many of the children with more malformed hearts will have succumbed by that age.

One should be interested in the patient's exercise tolerance since it may enable you to prognosticate and in certain instances aid you in deciding when a particular surgical procedure is carried out.

One should ask if a child "squats" when tired or if he frequently assumes the knee chest position for this is characteristic of cyanotic children when there is a decrease pulmonary blood flow. There are reports in the literature of squatting in occasional patients with complete transposition of the great vessels and Eisenmenger Complex but I would estimate that 98 per cent of "squatters" have Tetralogy of Fallot.

Ask the parents if the child has stridor, throws his head back in order to breathe, wheezes, has dysphagia or has repeated bouts of pneumonia for these symptoms are observed when a vascular ring is present. Most cases of stridor in the newborn are due to atelectasis but a vascular ring must never be overlooked since it can be corrected surgically.

Is there a history of leg weakness and cramps on exercise? Do wounds of the extremities heal poorly? Affirmative answers to these questions suggest coarctation of the aorta.

Physical examination. Inspection: First looking at the child as a whole, determine if stunting of growth is present since it occurs in certain types of congenital heart disease.

Does the child have Mongolian features? If he does, and acyanotic heart disease is present, he may have an atrioventricularis communis.

If the patient is a girl with ovarian agenesis coarctation of the aorta may be present. Dr. Fuller Albright has observed several cases of this rare but interesting condition.

Does the patient have arachnodactyly? This condition, due to a genetic deficiency of mesodermal tissue, is characterized by long slender limbs, fingers and toes, "webbing" of the fingers, a high arched palate, and prominent supraorbital ridges. Deformities of the spine and other chest deformities are common. Ocular lesions consisting of strabismus, nystagmus and subluxation of the lenses are common. In addition to skeletal and ocular lesions a fair per cent will have congenital heart disease, particularly patent foramen ovale. Other septal lesions both auricular and ventricular, have been reported. I have observed several cases who died as a result of dissection of the aorta.

Patients with coarctation of the aorta are frequently robust exhibiting good muscular development of the trunk and arms whereas the patient with interatrial septal defect may be poorly developed and have delicate features.

Is the child deaf and does he have cataracts? These findings associated with congenital heart disease complete the syndrome now known as the Gregg-Swan or German

measles syndrome. Various types of congenital cardiac defects have been reported in children with this condition.

Is cyanosis present? The color of the lips, tongue, finger nail beds etc., may establish the presence of slight to moderate cyanosis but as mentioned earlier a minor degree of arterial oxygen unsaturation may not manifest itself as obvious cyanosis. Occasional patients with coarctation of the aorta may have a patent ductus arteriosus which empties below the area of coarctation and the toes may be slightly cyanotic compared to the normal appearing fingers. The antithesis of this is seen in patients with coarctation of the aorta, patent ductus arteriosus emptying below the aortic block, and transposition of the great vessels where the finger tips are more cyanotic than the toes.

There are fourteen lesions commonly encountered which can be divided into two groups depending on whether or not cyanosis is present. (1) There will be no cyanosis in the patients with vascular ring unless there is trachial obstruction or atelectasis. (2) Cyanosis does not occur in patients with *uncomplicated* patent ductus arteriosus. (3) Patients with an aortic septal defect are usually acyanotic but, strange as it seems may be cyanotic. (4) Patients with coarctation are not cyanotic. (5) Patients with interatrial septal defect may be cyanotic during the first few hours of life but later have no cyanosis for a considerable period. As years go by and heart failure ensues there may be a reversal of blood flow through the defect sufficient to produce cyanosis. In addition the longstanding pulmonary hypertension

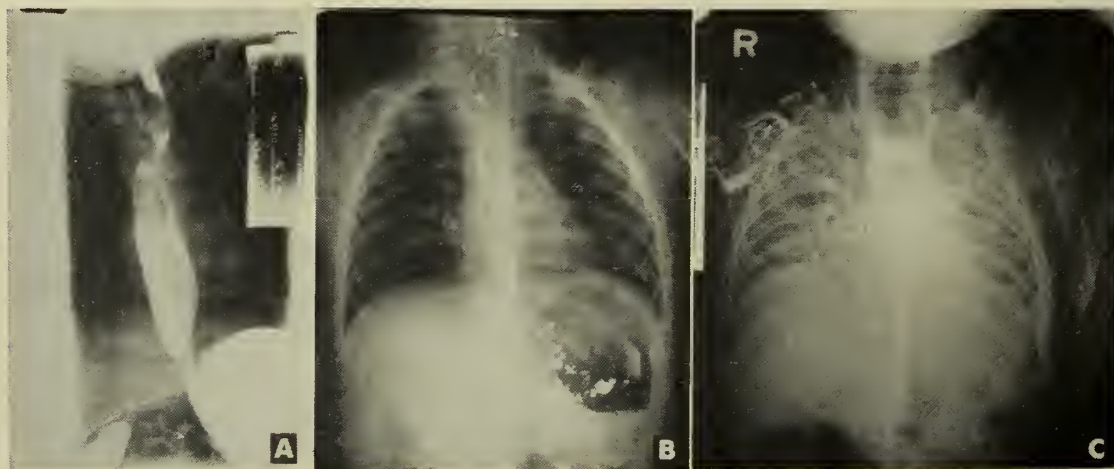
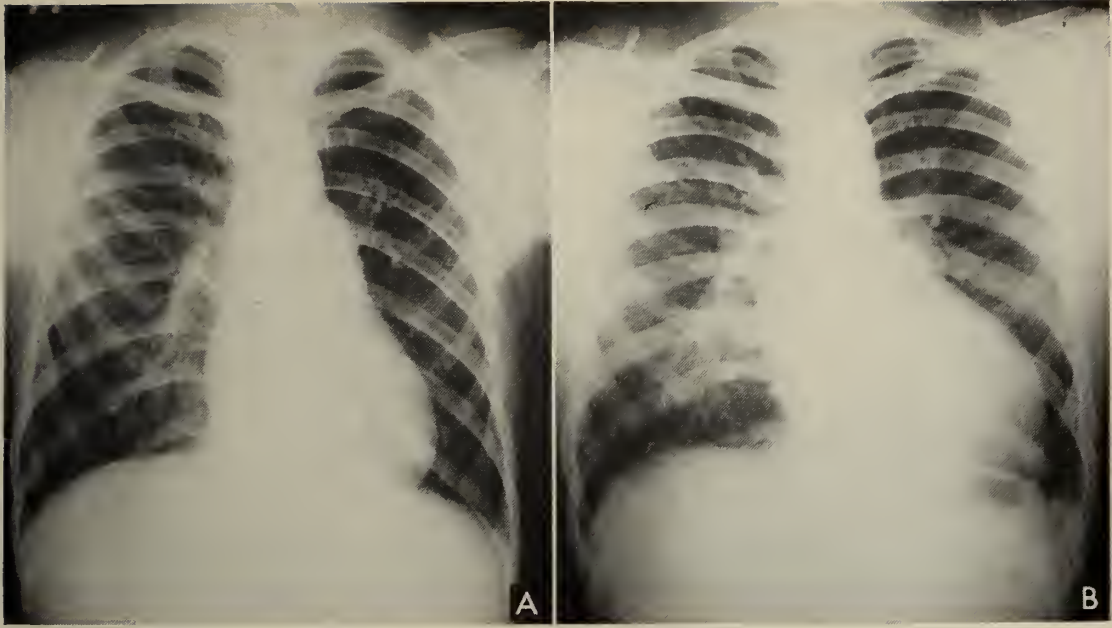


Fig. 1. Vascular ring. Figure one A shows indentation of the barium filled esophagus. Figure one B shows lipiodol in the trachea and figure one C shows the double aortic arch after diodrast injection.



A. Slight Cardiac Enlargement
 B. Moderate Cardiac Enlargement
 Fig. 2. Patent Ductus Arteriosus (Note prominent main pulmonary artery in figure two A).

may produce pulmonary arteriolar disease which may contribute to the cyanosis. (6) Patients with interventricular septal defect are not cyanotic. (7) Patients with idiopathic dilatation of the pulmonary artery are not cyanotic. (8) Nearly all patients with pure pulmonary stenosis are acyanotic. They may have acrocyanosis due to the complete tissue extraction of oxygen from the blood but do not have typical cyanosis and their arterial oxygen saturation is normal. (9) The Tetralogy of Fallot consists of dextroposition of the aorta to a point where it overrides the ventricular septum, high ventricular septal defect, pulmonary stenosis and right ventricular hypertrophy. Such patients may have no cyanosis at birth and no visible cyanosis as long as the ductus is patent but as the ductus closes they become more cyanotic and remain so the remainder of their lives. (10) The patients with pulmonary stenosis associated with a patent foramen ovale have minimal cyanosis early in life and it is typical for it to progress as they grow older. (11) Patients with tricuspid atresia are intensely cyanotic. (12) Patients with truncus arteriosus may or may not be cyanotic. If the pulmonary arteries arise from the common trunk there may be minimal cyanosis but if no pulmonary arteries are present, and the lungs' blood flow is derived from bronchial arteries alone, cyanosis will be intense. (13) Patients who have com-

plete transposition of the great vessels are intensely cyanotic. (14) The Eisenmenger complex consist of dextroposition of the aorta to the point where it over-rides the ventricular septum, high ventricular septal defect, right ventricular hypertrophy and occasionally congenital aorta valve disease with upward displacement of the coronary arteries. Such patients may have minimal or even no cyanosis early in life but later, frequently at puberty, develop moderate cyanosis which is progressive.

After inspecting the child as a whole it is practical to next observe certain specific parts of the body in our search for clues.

Clubbing of the fingers is associated with long standing cyanosis but it is, at times, difficult to detect during the first few years of life.

One should carefully inspect and record the observation of the arterial pulsations seen in the neck. Prominent pulsations will be present in patent ductus arteriosus, aortic septal defect, Tetralogy of Fallot, Eisenmenger's complex and coarctation of the aorta. Unfortunately the most common cause of prominent arterial pulsations in the neck is anxiety and one must be certain this is *not* the cause before attaching significance to such pulsations.

Next inspect the precordium. If there is a left sided anterior chest deformity or bulge this suggests right ventricular hypertrophy.

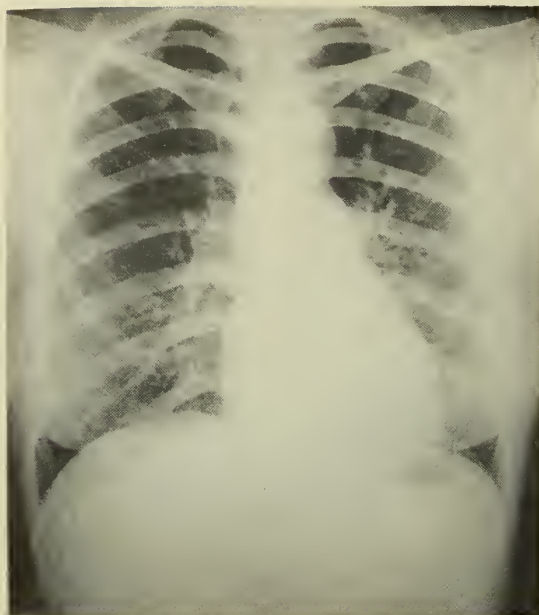


Fig. 3. Aortic Septal Defect. (The main pulmonary artery and its branches pulsate vigorously on fluoroscopic examination).

Palpation: Next feel carefully for femoral arterial pulsations and dorsalis pedis pulsations since their absence is a strong clue that coarctation of the aorta is present. The palpation of such pulsations is difficult in the newborn and *care and time* is needed to interpret the findings because I have seen newborn without coarctation in whom I could not feel femoral artery pulsations. As the child grows older the pulsations should be easily felt. In the older person spontaneous thrombosis of the lower part of the aorta may reduce or eliminate the femoral arterial pulsations and the clue to the diagnosis is to feel aortic pulsations above the arterial thrombosis.

Next palpate the anterior chest for thrills for they usually attend loud murmurs.

With care one can frequently see and feel the pulsations of the pulmonary artery in the second or third left interspace in patients with pulmonary hypertension and dilated pulmonary arteries.

Heart size and enlargement are difficult to determine in the very young since the heart is hardly larger than a lemon. A centimeter enlargement can easily be overlooked and in the child a centimeter represents considerable enlargement since the heart is normally so small. If on inspection and palpation the apex impulse is definitely outside the left border of normal zone and if one can state the heart is definitely large in a cyanotic

child this speaks for transposition of the great vessels rather than Tetralogy of Fallot.

While palpating the precordium it is useful to press the hand firmly on the lower end of the sternum and see if a systolic propulsion is present suggesting right ventricular hypertrophy.

Finally complete the palpatory portion of the examination by studying the size of the liver and its pulsations.

The blood pressure should be recorded in both arms and legs since a lower arterial pressure in the legs than in the arms indicates coarctation of the aorta. The blood pressure is technically difficult to record in the newborn and infant even when a small cuff is used and therefore femoral pulsations may remain the only clue to coarctation in the early months of life.

Percussion: Percussion is of little value in examining the patient with congenital heart disease but may confirm the location of the left cardiac border and aid in attempting to determine the heart size.

Auscultation: The presence of murmurs may or may not be helpful because: (1). The mere presence of a murmur does not necessarily indicate heart disease. Indeed murmurs are heard in most perfectly normal children. (2) If one hears a murmur which is definitely abnormal he may be able to state that *heart disease is certainly present* but the murmur could be produced by a number of defects and that information in



Fig. 4. Coarctation of the Aorta (note rib notching).

addition to the abnormal murmur is necessary to say which of several defects produces that particular murmur. For instance the murmur of pulmonary stenosis, Eisenmenger's complex, Tetralogy of Fallot, pulmonary stenosis with patent foramen ovale, transposition of the great vessels, truncus arteriosus and interventricular septal defect may be quite similar. (3) Severe congenital heart disease may be present without producing a significant murmur. For instance in tricuspid atresia only a slight murmur may be present and *no* murmur may be heard when complete pulmonary artery atresia is present. (4) On the other hand the presence of the typical murmur of patent ductus is diagnostic except on rare occasion when it is due to aortic septal defect. (5) In the very young it may be difficult to localize a murmur with any degree of accuracy because of the small heart size and wide murmur transmission.

A normal pulmonary systolic murmur may be heard at birth because the pressure in the pulmonary vascular bed has suddenly dropped allowing systolic blood flow through the ductus. This murmur may later disappear as the pressure relationship becomes stable and normal. The ductus is then functionally closed but not anatomically closed.

We are all familiar with the slight systolic murmur heard at all valve areas of the child. This is particularly common in the pulmonary area and these are most often within the normal range.

More confusing and frequently overlooked is the ever present venous hum of the child. It is difficult to understand how such a continuous murmur is produced. I suspect it is due to the superficial nature of the veins, their size and relative pressure differential which is different in the adult and child. This murmur is heard in systole and diastole but is maximum in diastole and at times is only heard during systole. It is heard in the neck and on occasion is heard in the pulmonary area where it may be confused with a ductus. This murmur is very superficial and has a "hollow" sound. It is heard best with the patient sitting and decreases or vanishes when the patient lies down. Its intensity and quality varies greatly as the head is turned from side to side and can be eliminated by pressure on the proper cervical veins. Identifying such a murmur may be more difficult than it sounds for the child is frequently crying, moving and hold-

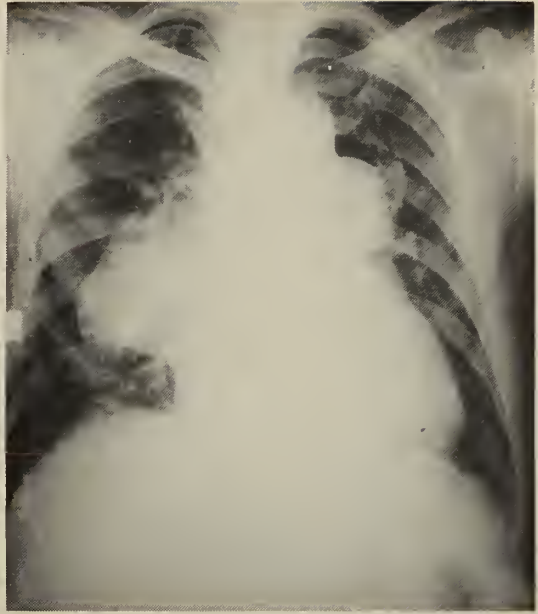


Fig. 5. Interatrial septal defect plus rheumatic heart disease with aortic insufficiency and mitral stenosis. (Eisenmenger's complex cannot be excluded). See contents for discussion.

ing his breath all of which alters the characteristics of the murmur.

The venous hum is a normal continuous murmur but abnormal continuous murmurs are heard in patent ductus arteriosus, aortic septal defect, pulmonary A-V fistula and the extensive collateral circulation associated with truncus arteriosus.

The murmurs of the fourteen defects described under cyanosis will now be discussed: (1) The patient with a vascular ring will present no abnormal murmurs unless a cardiac defect is also present. (2) The murmur of patent ductus arteriosus may only have a systolic component during the first one or two years of life. This murmur is heard in the pulmonary area and it may be impossible to differentiate it from the normal pulmonary murmur. As the child grows older and the diastolic pressure in the systemic circulation exceeds that in the pulmonary circulation a continuous murmur will be heard in the pulmonary area. There is usually systolic accentuation of the murmur and it is usually loudest with the patient lying down. After the age of two and three nearly all cases of patent ductus will have a continuous murmur but on rare occasion only a systolic murmur is heard even in the older age group. In about twenty-five per cent of the cases a "rapid filling" mitral diastolic rumble will be heard which will disap-

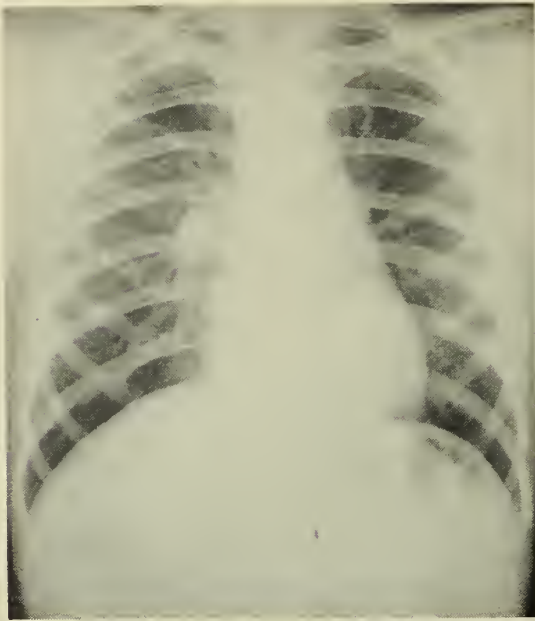


Fig. 6. Interventricular septal defect (Slight generalized cardiac enlargement).

pear after ligation of the ductus. (3) The murmur of aortic septal defect is characteristically continuous and may be confused with the murmur of a patent ductus. This defect is more common than we have previously suspected. Out of the 100 odd cases of "patent ductus" operations performed here by Doctors Abbott and Hopkins three have been found to have aortic septal defects. We have two additional nonoperated cases. The murmur may be identical to that of the patent ductus but if it is heard maximally beneath the sternum or in the aortic area, is more superficial or is in any way peculiar one should think of aortic septal defect. In one of our proven cases, a 30 year old female, there was only a systolic murmur in the third and fourth left intercostal space next to the sternum. There is a patient at Grady now whom I suspect has a similar lesion. (4) The systolic murmur heard in coarctation of the aorta is heard at the base of the heart and along the left sternal border but may be just as loud or louder over the dorsal spine. Murmurs may be audible over the collateral vessels which are a prominent feature of coarctation of the aorta. There is a fairly high incidence of subaortic stenosis and bicuspid aortic valves in coarctation of the aorta and therefore the systolic murmur of subaortic stenosis and the diastolic murmur of aortic insufficiency are frequent. (5) The auscultatory findings of interatrial septal defect are very variable. I

have seen cases with no murmurs or only a slight systolic murmur in the pulmonary area and on the other hand I have heard loud murmurs with such a defect. If the defect is low in the atrial septum the so-called ostium primum defect, there may be a fairly loud murmur heard maximally in the third and fourth left interspace near the sternum. This may resemble the murmur of interventricular septal defect and anatomically the low atrial septal defect is as low as the interventricular septal defect. If the defect is higher in the atrial septum the murmur may be less intense and heard at a higher level. This type of defect is frequently termed a patent ostium secundum. It is difficult for me to understand the physiology of the murmur production in these cases. Why are the murmurs not presystolic in time since the maximum blood flow occurs during auricular systole? Actually the murmur is heard during auricular diastole but if auricular fibrillation or heart failure ensues the murmur may diminish or vanish. The systolic murmur in the pulmonary area may be due to a dilated pulmonary artery. The pulmonary second sound may be loud. Any patient with pulmonary hypertension may have pulmonary regurgitation and this is especially true with interatrial septal defect. If there is a diastole rumble at the apex one then makes the diagnosis of Lutembacher's syndrome which is an atrial septal defect plus congenital or acquired mitral stenosis. In most cases the mitral stenosis is rheumatic in origin. The atrial septal defects are interesting and the murmurs may not be diagnostic. The greatest aid to diagnosis is the fluoroscopic exam. (6) The murmur of an interventricular septal defect is systolic in time and is usually loud and rasping. It is heard with maximum intensity in the third and fourth left interspaces near the sternum. Additional information is needed to state that it is an uncomplicated septal defect and it may be impossible on occasion to differentiate the I-V septal defect murmur from the murmur of pulmonary stenosis by auscultation alone. (7) A systolic murmur in the pulmonary area may be heard in patients with idiopathic dilatation of the pulmonary artery. This murmur at times may be intense enough to be confused with the murmur of pulmonary stenosis and again additional information is needed to establish a diagnosis. (8) The systolic murmur of pure pulmonary stenosis is usually loud and rasping and the area of

maximum intensity is in the second and third left interspaces near the sternum. *One must realize, however, that in young patients and particularly infants that murmurs are so widely transmitted that it may be impossible to precisely locate a point of maximum intensity* and the murmurs of pulmonary stenosis and I-V septal defect may be similar. Occasionally one may hear a slight murmur of pulmonary insufficiency in patients with pure pulmonary stenosis due to inadequate closure of the pulmonary valves during diastole. (9) The murmur heard in Tetralogy of Fallot is systolic in time and may be heard over the entire precordium but is usually loudest along the left sternal border in the second, third and fourth interspaces. If the pulmonary artery is exceedingly small, absent or atretic no murmur may be heard. In such a case one could postulate that the right and left ventricular systolic pressures were about equal thus eliminating murmur production by the I-V septal defect. (10) The murmur heard with pulmonary stenosis and patent foramen ovale resembles the murmur of pure pulmonary stenosis. (11) The patient with tricuspid atresia may have no murmurs or only a slight systolic murmur. The patent atrial septum which frequently accompanies this lesion is large and the pressures are low so that the atria function as a single chamber and murmur production is slight. If a patent ductus remains it represents an extension of the ventricular outflow without the pressure differentials necessary for murmur production. Occasionally an interventricular septal defect may be present and produce a typical murmur. (12) The murmur of truncus arteriosus is systolic in time and precordial in location. The murmur is loud and widely transmitted having the characteristics of an interventricular septal defect. I can recall one case, however, that had no murmur. On occasion there may be a continuous murmur on either side of the upper sternum due to extensive pulmonary collateral circulation. (13) The murmur heard in complete transposition of the great vessels depends on the associated defect which is always present if the patient lives. The murmur of interventricular or auricular septal defect may be present. Although a ductus may be present a characteristic murmur is rarely heard because the pulmonary arterial and aortic pressures are fairly equal during early life. As is so often the case the presence of an abnormal murmur indi-

cates heart disease but additional measures are needed to state which malformation is present. (14) The auscultory findings in patients with the Eisenmenger complex are variable. Cases have been reported where only a slight systolic murmur in the pulmonary area was heard. On the other hand the characteristic murmur of interventricular septal defect is frequently present. The murmur of aortic insufficiency may occasionally be heard because an associated aortic valve lesion is sometimes seen in the Eisenmenger complex.

The intensity of the pulmonary second sound is of little value in the child since one can never be certain that the aortic second sound is not being heard. If a reduplicated second sound is heard at the base, suggesting two valves, a truncus arteriosus is eliminated. In my experience this is of little value however. In the adult the intensity of the pulmonary second sound is of more value and is frequently very loud when there is pulmonary hypertension. Strange as it seems, however, a loud pulmonary second sound can occur in pulmonary stenosis.

Auscultation of the lung bases for rales is helpful. Rales are uncommon in defects of the heart producing a decreased pulmonary blood flow but are frequently heard with defects associated with an increased blood flow to the lungs.

Electrocardiography: Following the history and physical exam an electrocardio-



Fig. 7. Idiopathic dilatation of Pulmonary Artery (Unproven).

gram is made. The electrocardiogram may be normal, show right or left ventricular hypertrophy or certain conduction defects. An etiologic diagnosis can never be made from the electrocardiogram alone and it is of diagnostic value only in the light of other clinical data. (1) The patient with an uncomplicated vascular ring has a normal electrocardiogram. (2) The electrocardiogram is most often normal with patent ductus arteriosus. It occasionally shows left ventricular hypertrophy but for practical purposes does not show right ventricular hypertrophy. *If hypertrophy of the right ventricle is present an additional lesion must be considered. This is very important since one would not ligate a ductus when it is associated with Tetralogy of Fallot.* (3) The electrocardiogram in aortic septal defect should be similar to patent ductus. In my experience left ventricular hypertrophy has been slightly more common. (4) The patient with coarctation of the aorta has a normal electrocardiogram or it may show left ventricular hypertrophy. (5) The electrocardiogram in interatrial septal defect shows right ventricular hypertrophy, right bundle branch block, large P waves and occasionally auricular fibrillation. (6) The electrocardiogram in interventricular septal defect is normal or shows left ventricular hypertrophy. (7) The electrocardiogram is normal in patients with idiopathic dilatation of the pulmonary artery. (8) The electrocardiogram in pure pulmonary stenosis almost always shows right ventricular hypertrophy. *Occasional cases have normal electrocardiograms for the degree of right ventricular hypertrophy depends on the degree of stenosis and the age of the patient.* (9) The electrocardiogram in Tetralogy shows right ventricular hypertrophy and prominent P waves. (10) The electrocardiogram in pulmonary stenosis with patent foramen ovale shows right ventricular hypertrophy and prominent P waves. (11) The electrocardiogram is of great value in the diagnosis of tricuspid atresia. Due to underdevelopment of the right ventricle left ventricular hypertrophy may be present. At times, in such cases, there may merely be the absence of the expected degree of right axis deviation. *If one sees a cyanotic child and the electrocardiogram shows left ventricular hypertrophy he should immediately suspect tricuspid atresia.* (12) The electrocardiogram in truncus arteriosus shows large, wide swinging, QRS complexes with-

out preponderance of either ventricle and is of little diagnostic value. (13) The electrocardiogram in complete transposition of the great vessels shows right ventricular hypertrophy. (14) The electrocardiogram in the Eisenmenger complex usually shows right ventricular hypertrophy but may be normal.

I do not propose to discuss the electrocardiogram this morning but I would like to point out one obstacle in its use. The normal newborn's electrocardiogram shows right ventricular hypertrophy and therefore the electrocardiogram will not be helpful in determining abnormal right ventricular hypertrophy secondary to congenital cardiac defects. We are now working on this problem but as yet no useful clue has become obvious.

Laboratory data: Erythrocytosis and a sedimentation rate of zero is the rule when there is arterial oxygen unsaturation. An occasional patient with cyanotic heart disease will have an elevated NPN and the reason for this is not clear.

Fluoroscopic exam and x-ray: After the above procedures have been carried out and the findings reviewed the patient should be carried to the fluoroscopic room. Here we work closely with the x-ray department and discuss all details of the case with them. The radiologist and cardiologist then fluoroscope the patient together. In the average case the following questions must be answered when the patient is fluoroscoped. (1) Does the heart appear to be enlarged in the antero-

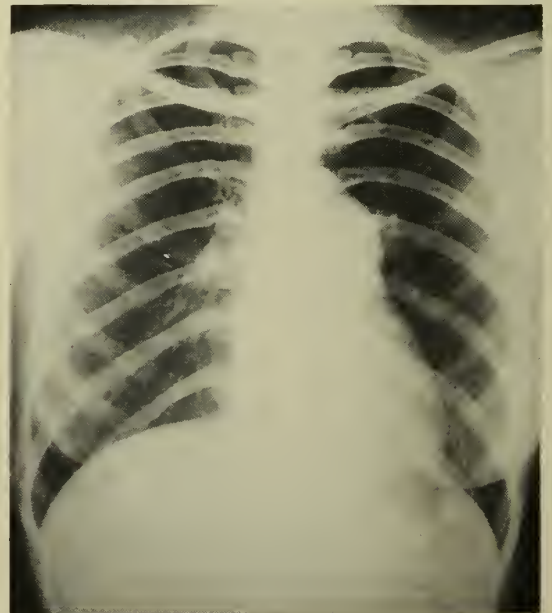


Fig. 8. Pure pulmonary stenosis (The main pulmonary artery is large but decreased pulsations are seen on fluoroscopic examination).

posterior view? Are the great vessels normal in size and position? (2) Is the right ventricle enlarged? The left and right anterior oblique views are utilized in determining right ventricular hypertrophy. (3) Is the left ventricle enlarged or is it small? The left anterior oblique view is used to study the left ventricle. (4) Is the main pulmonary artery large and does it pulsate? (5) Is the main pulmonary artery small or absent? (6) Do the secondary pulmonary arterial branches, the hilar vessels, pulsate normally or are the pulsations increased or decreased? This is an extremely important question to answer for it alone, at times, decides whether or not surgery is indicated. (7) Are collateral vessels visible? (8) A drink of barium is then given the patient. Even the very young can be given small amounts of radio opaque material and we occasionally insert a small catheter into the esophagus and use lipiodol. Is the barium filled esophagus indented by aberrant vessels? Which side of the esophagus is indented by the aorta? Is the left atrium large?

During the fluoroscopic exam "spot" films are taken of important findings worth recording and finally six foot P-A, left anterior oblique and right anterior oblique films are obtained. The x-rays are then studied and a final x-ray report is prepared. The fluoroscopic and x-ray findings of the defects described earlier in this discussion will now be presented. (1) Vascular ring: The several types of vascular ring can be identified by detecting aberrant vessels encroaching on the barium filled esophagus. At times the injection of lipiodol into the trachea will be helpful. An example of a double aortic arch is shown in figure one. Figure one A shows indentation of the barium filled esophagus. Figure one B shows the constriction of the lipiodol filled trachea and figure one C shows the double aortic arch after intravenous diodrast injection. (2) Patent ductus arteriosus: The contour of the heart may be normal or both ventricles may be enlarged. The main pulmonary artery *may* or *may not* be prominent. If the shunt is large enough the main pulmonary artery and its secondary branches can be seen to pulsate vigorously. It is not uncommon to observe slight left atrial enlargement. It should be emphasized that in many instances it is impossible to detect *any* differences between the fluoroscopic findings of a normal heart and those associated with a patent ductus arteriosus.

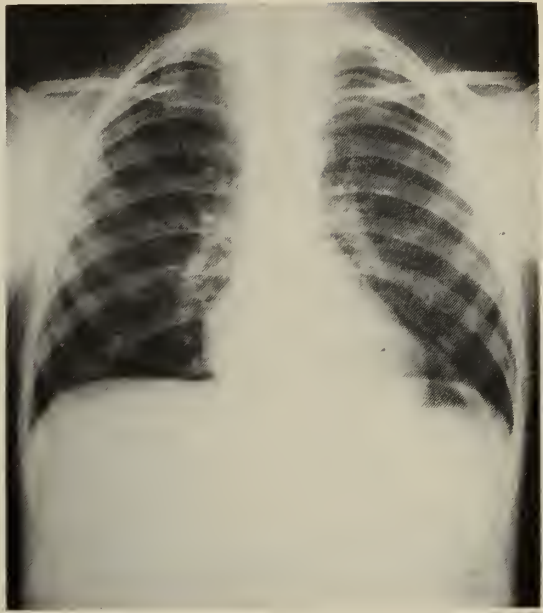
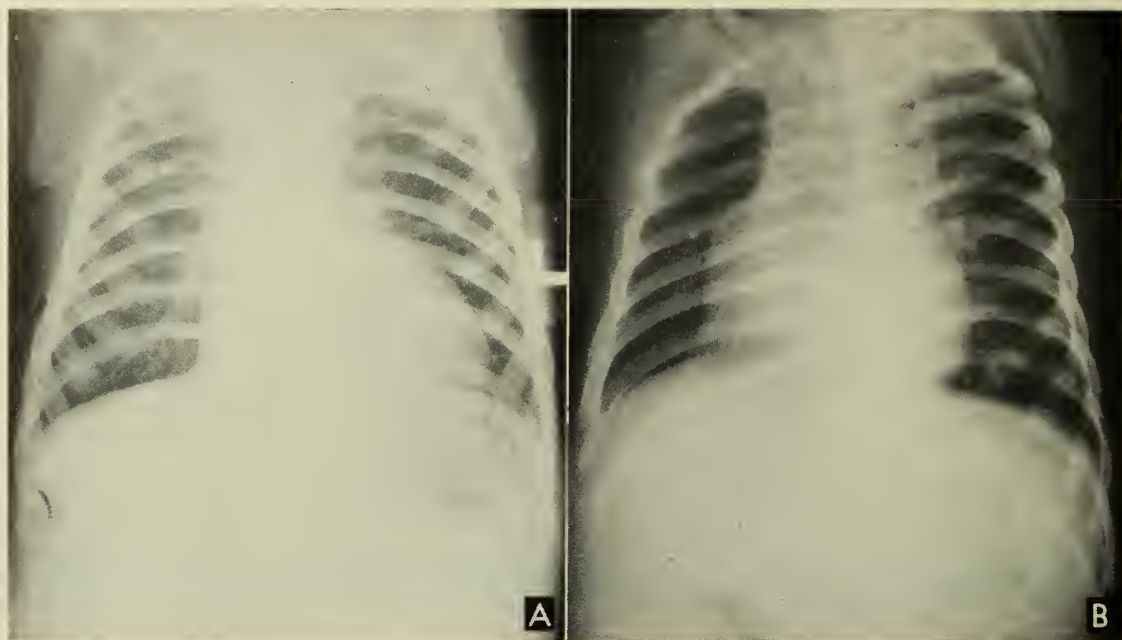


Fig. 9. Tetralogy of Fallot (The main pulmonary artery cannot be seen and vascular markings are limited to the hilar region. The hilar vessels do not pulsate).

Figure two shows two cases of patent ductus, one case showing a fairly normal size heart and one showing moderate generalized enlargement. (3) Aortic septal defect: The findings should be similar to those of patent ductus arteriosus. It is my impression, however, that the shunt is usually greater and that a large pulmonary artery and vigorous hilar vascular pulsations are more common. Figure three is an example of a proven aortic septal defect. (4) Coarctation of the aorta: The aortic knob may be large, small or normal in size. The heart itself may be normal in size or the left ventricle may be enlarged. Notching of the ribs—scalloping of the lower rib margins—is a frequent finding particularly after the age of ten (see Fig. four). (5) Interatrial septal defect: The right ventricle and right atrium are almost always enlarged. The main pulmonary artery and its right and left branches are usually large. At fluoroscopy the main pulmonary artery and its secondary branches can be seen to pulsate vigorously indicating an increase blood volume and flow. An occasional case has a normal sized pulmonary artery. The pulmonary artery and its branches are tremendous in cases of the Lutembacher complex. Figure five shows the x-ray of an adult with interatrial septal defect and rheumatic heart disease with mitral stenosis and regurgitation and slight aortic regurgitation. Note



A. P-A View

B. Left Anterior Oblique

Fig. 10. Tricuspid Atresia (Pulmonary vascular markings are decreased and the left ventricle is seen to be large in the left anterior oblique view).

the tremendous size of the pulmonary artery. This patient has recurrent pneumonia because one of the pulmonary artery branches obstructs one of the segmental bronchi. The fluoroscopic findings of Eisenmenger's complex and interatrial septal defect may be quite similar and on occasion impossible to differentiate. (6) Interventricular septal defect: The fluoroscopic and x-ray findings of interventricular septal defect do not deviate from the normal. Occasionally there is slight generalized cardiac enlargement. If the defect is high in the ventricular septum the findings may then be similar to an interatrial septal defect. This is particularly true during the first few years of life. The x-ray of a patient with interventricular septal defect is shown in figure six. (7) Idiopathic dilatation of the pulmonary artery: There is *no* enlargement of the chambers of the heart but the main pulmonary artery and occasionally its branches are quite large. The pulmonary artery and *hilar vascular pulsations are normal*. I would like to stress the fact that it is common to see a fairly large pulmonary artery segment in young individuals. The pulmonary artery is much larger in the syndrome known as idiopathic dilatation, however, and at times reaches aneurysmal proportions. Idiopathic dilatation of the pulmonary artery is illustrated by the x-ray shown in figure seven. (8) Pure pulmonary

stenosis: The right ventricle is almost always enlarged. Strange as it may seem the main pulmonary artery is frequently enlarged. The secondary pulmonary artery branches are less commonly dilated. Post stenotic dilatation of the pulmonary artery is usually associated with the "diaphragmatic" type of pulmonary stenosis. This type of stenosis is more common when there are no other lesions and the pulmonary stenosis of Tetralogy of Fallot is more often of the infundibular type. At times there may be both diaphragmatic and infundibular stenosis. The pulsations of the pulmonary artery and its branches are usually decreased and may be absent. I have occasionally observed fairly normal pulsations of the main pulmonary artery and the value of the exam then lies in the fact that the pulsations are not *increased*. An example of pure pulmonary stenosis is illustrated by the x-ray shown in figure eight. (9) Tetralogy of Fallot: During the first few months of life the heart may appear normal but later a fairly characteristic contour becomes evident. In the anterior-posterior position the heart is normal in size but the pulmonary artery is small and therefore there is a concavity in the region of the pulmonary artery segment. The cardiac apex may appear to be tilted upward. The lung fields are usually clear due to diminished pulmonary circulation and hilar

vascular shadows are decreased and do not pulsate. Pulmonary collateral circulation may become extensive enough to be seen but is limited to the hilar region and does not pulsate. The right ventricle is seen to be enlarged in the left and right anterior oblique positions. A study of the barium filled esophagus shows a right sided aortic arch in about twenty-five per cent of the cases. The preceding findings are seen in the usual case but occasionally a pulmonary artery is visible and slight pulsations can be detected and the cardiac apex may not be "tilted" upward. The x-ray findings of a typical case of Tetralogy of Fallot is shown in figure nine. (10) Pulmonary stenosis with patent foramen ovale: The x-ray findings are similar to those of pure pulmonary stenosis. (11) Tricuspid atresia: The findings in the anterior-posterior position resembles Tetralogy of Fallot since the lung vascular markings are decreased and the pulmonary artery is not visible. The right border of the heart is occasionally straight. The right ventricle is not enlarged, in fact it is quite small, and in the left anterior oblique view the diminutive right ventricle does not extend much farther anteriorly than does the aorta and the left ventricle appears fairly large. The x-rays of a case of tricuspid atresia are shown in figure ten. (12) Truncus arteriosus: The heart is usually fairly large as viewed in the A-P view. The "aorta" is frequently quite large and indents the esophagus. The "aorta" appears large because in reality it is a combination of the pulmonary artery and aorta producing a common trunk. The pulmonary artery may not be present and a concavity in that region will result. The hilar vascular markings are diminished. If the pulmonary arteries arise from the common trunk they are occasionally seen but arise at a higher level than usual. A rather acute angle is formed by the "trunk" and cardiac shadow below it on the left side in the AP view and anteriorly in the left anterior oblique view. This is sometimes referred to as the "shelving process." Occasionally the bronchial arteries, which become fairly large, are seen above the hilar region in the region of the aortic knob. The x-rays of a case of truncus arteriosus are shown in figure eleven. (13) Complete transposition of the great vessels: The heart is usually enlarged to the right and left when viewed in the A-P position. The great vessels at the base of the heart

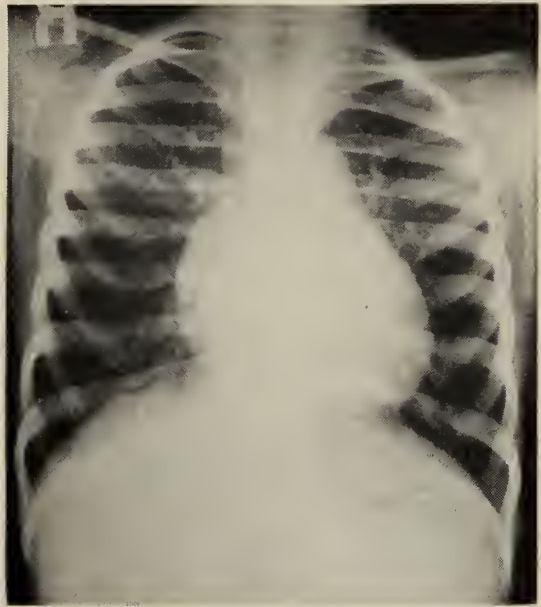


Fig. 11. Truncus arteriosus (Note the large "aorta". Large bronchial arteries are seen above the right hilum. The pulmonary vascular markings are diminished. The "shelving process" can be seen best in a left anterior oblique view).

must be studied with care. In the A-P view the shadow of the great vessels appears narrow. In the left anterior oblique view the shadow becomes wider. There is frequently an absence of the pulmonary artery shadow because the pulmonary artery is located somewhat behind the aorta in transposition of the great vessels. Both ventricles are enlarged. The hilar vascular markings are frequently obvious since there is adequate blood flow to the lungs in this condition. At times these markings are greatly increased particularly when heart failure is present. X-rays illustrating transposition of the great vessels are shown in figure twelve. (14) The Eisenmenger complex: In the A-P view the pulmonary artery may be markedly dilated but is occasionally normal in size. When the pulmonary artery is large it is seen to *pulsate vigorously* resembling that of interatrial septal defect. In the left oblique view the right ventricle is seen to be enlarged. In my experience it is quite difficult to definitely diagnose the Eisenmenger complex. See figure thirteen.

After completing the above routine procedures and analyzing all the available data, patients will fall into one of four groups:

(1) Patients in whom the diagnosis is reasonably definite and surgery is indicated or contraindicated.

(2) Very young patients who cannot be diagnosed with certainty, but who are doing well. These patients should be restudied at intervals, the length of the interval depending on the condition of the child.

(3) Patients in whom a definite diagnosis cannot be made but from a practical standpoint it is possible to say that an operation is not indicated.

(4) Patients in whom additional procedures are needed and should be carried out in order to establish a diagnosis. *Fortunately this group is small.* A few of the other laboratory procedures are considered below.

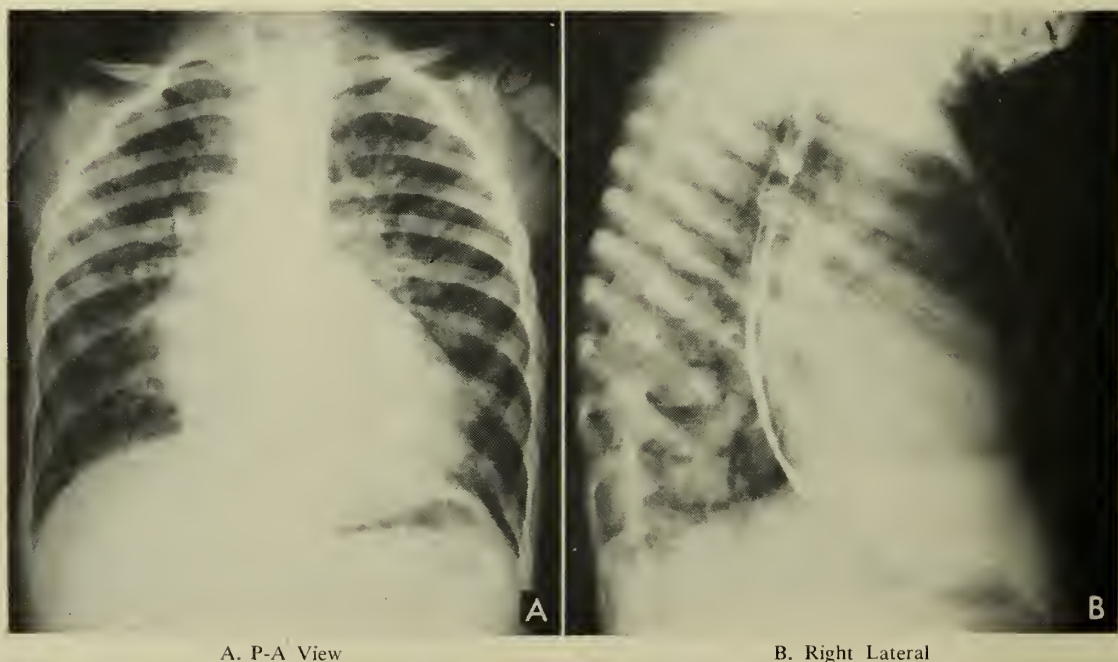
Additional laboratory procedures: A few cases of congenital heart disease require additional laboratory measures to establish a diagnosis. These procedures such as cardiac catheterization, diodrast studies, arterial puncture and respiratory studies have certain drawbacks. To begin with it is almost impossible to perform the procedures in children under four years of age. This is unfortunate because this is the very group so frequently requiring additional measures for diagnosis. Even in the older group of patients it may be impossible to obtain the small bit of information needed to establish the diagnosis. Mistakes in laboratory data occur from time to time in the best labora-

tory to confuse the picture rather than clarifying it. Finally it must be stated that diodrast studies and cardiac catheterization are not without danger particularly in the cyanotic group of congenital heart disease.

In general cardiac catheterization yields information about defects in which there is a left to right shunt and diodrast studies give more information about defects in which there is a right to left shunt. The rare patient with a patent ductus arteriosus with only a systolic murmur can be diagnosed by cardiac catheterization if one is able to obtain pulmonary artery and right ventricular blood samples. If one is uncertain about the presence of pulmonary stenosis the findings of pulmonary hypotension and right ventricular hypertension establishes the diagnosis.

In my experience it has been useful to ask myself two questions before performing either cardiac catheterization or angiocardio-graphy: (1) What additional information is needed, in the light of the other clinical findings, to establish the diagnosis? (2) How difficult will it be to obtain such data? Never depend on angiocardio-graphy or catheterization alone for a diagnosis but add the new information to the previous data and then attempt to establish a diagnosis.

From an academic standpoint cardiac



A. P-A View

B. Right Lateral

Fig. 12. Transposition of the great vessels (Note the increase pulmonary vascular markings, moderate cardiac enlargement, concave pulmonary artery segment, right ventricular hypertrophy and narrow vascular pedicle in the P-A view).

catheterization may help establish the diagnosis even though there is no present operation for such a defect. A certain amount of controlled academic study is desirable since the information may prompt newer therapeutic measures. Certainly a great deal of cardiovascular physiology has been discovered from the congenital cardiac patients as well as normal patients. For example, at times it may be impossible to differentiate the Eisenmenger complex from interatrial septal defect by clinical means. The cardiac catheter and angiocradiography are useful adjuncts which may help to establish the diagnosis. One can state clinically that an operation is not available in either case but if a group of trained cardiovascular investigators is attempting to study these diseases, and devise operations for them, detailed study is necessary. In this case a definite project with a definite goal is in mind and useful information might be expected to be forthcoming. Contrariwise the *haphazard selection* of occasional patients without a definite plan or goal probably yields no useful information even from an academic point of view.

To re-emphasize, from a practical point of view it is uncommon to need angiocradiography and cardiac catheterization to establish a diagnosis or to determine if an operation is feasible. Time will not allow detailed discussion of these procedures and perhaps this can be discussed at a later date.

Dr. Harvey Hamff: Which defects are operable?

Dr. Willis Hurst: Vascular ring, patent ductus arteriosus, coarctation of the aorta, Tetralogy of Fallot, pure pulmonary stenosis, pulmonary stenosis with patent foramen ovale and tricuspid atresia. The operation for transposition of the great vessels has not been too satisfactory and I am unhappy with it but I expect that some day the aorta and pulmonary artery will be retransposed by surgery. Defects in the atrial and ventricular septum have been closed but as yet the mortality is too high for routine application. I certainly hope it becomes practical to close the atrial defect for many of these patients are severely limited. At present aortic septal defect is not operable.

Dr. Henry Jennings: When are patients with patent ductus subjected to surgery?

Dr. Hurst: It depends on whether cardiac enlargement, congestive failure, limitation of



Fig. 13. The Eisenmenger's Complex (The main pulmonary artery and its right branch are prominent and on fluoroscopic examination pulsate vigorously).

activity, stunting of growth or subacute bacterial endocarditis is present. As a routine procedure, and if the patient is having no trouble, we like to have the operation about the fifth year or sixth year of life. If the patient is in trouble operation can, of course, be performed at an earlier age.

In conclusion, I would like to re-emphasize that from a practical point of view patients with congenital heart disease can be evaluated by the usual methods of examination, namely history, physical examination, electrocardiography and fluoroscopic examination. I have attempted to point out some of the diagnostic clues which have been proven to be of value. On rare occasions cardiac catheterization and diodrast studies may be necessary but even in these cases the diagnosis is usually made by combining the findings obtained from such procedures with the clinical findings. It is a mistake to assume that cardiac catheterization or diodrast studies alone will always establish a diagnosis.

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RECTAL BLEEDING

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PATIENTS seek advice from their family doctor concerning their colon and rectal regions because of bleeding, pain and fear of cancer. They fear cancer because of rectal bleeding or because someone of their circle of acquaintances develops a cancer. The patient wants an examination to find out "what's wrong with him", but actually he wants to know that he doesn't have cancer. The cause of pain may originate in the colon or rectal tissues or may be referred to this area from some neighboring organ. Pain may be minimized or exaggerated; it may be real or in the realm of the imaginary, but in any case the cause of the pain must be found and, if possible, eliminated. The cause of the bleeding must be evaluated carefully and accurately.

Bleeding from the rectum may be divided into occult and gross. The patient usually isn't aware of occult bleeding. However, some well informed patients know of this possibility because of widespread publicity given in the popular lay magazines, and on occasions requests have been made to perform examinations by patients who had read an article in the lay press on the cause of anemia. It has been estimated that a loss of as little as 50 cc. of blood anywhere in the intestinal tract will give a positive occult blood test in the stool. A positive test has been obtained by mixing one drop of urine containing 4-6 RBC per high field with a small fleck of stool. The test was made with fresh gum guaiac solution, and in my opinion this is the best test for office use. For proper and clinical evaluation the patient should abstain from all meat at least four days. Fish and fowl are permissible. And when a persistent positive occult test is obtained under these conditions it means that there is a break in the continuity of the mucous membrane of the gastrointestinal

tract. The cause of the break must be located.

Gross bleeding is what worries the patient most and brings him to his doctor for reassurance. Perhaps everyone has had at one time or other, transient anal bleeding. The most common cause of reappearing mild rectal bleeding in the adult is internal hemorrhoids. In children rectal polyps are the most common cause. Bright red blood means the bleeding is in the anal or perianal region or in the lower rectum. Dark red blood usually means bleeding high in the intestinal tract. Active bleeding high in the intestinal tract in the presence of quick bowel passage may bring down a bright red stool, and conversely, dark or tarry stools may be seen in the patient with a rectal lesion who is constipated. A stool containing pus and blood means an ulcerative and infected lesion.

In an extensive study Whitney³ has shown that there are about one hundred different causes of bleeding from the rectum. What concerns the patient is the likelihood of cancer. For whatever reason he seeks out his doctor, basically he wants to be told he does not have a cancer. After that he sighs a sigh of relief and then settles down to the program of getting well. Before we doctors can conscientiously tell our patients they do not have a cancer, a very careful history and physical examination must be done. If necessary, a repeat examination must be done, for example, after an obvious internal hemorrhoid has been sclerosed. One must be fairly certain a lesion in the colon does not exist before the hemorrhoids are treated.

A careful history will give a lead. A small stain on the clothing or on the toilet tissue after a defecation means minor anal lesion. Painless dropping of blood into the toilet bowl means internal hemorrhoids. A well formed stool with a blood streak on one side means a polyp. Dark red blood clots in the stool means a lesion in the sigmoid. Explosive, intermittent blood in the stool usually means a rectal lesion.

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Read before the Medical Association of Georgia in Annual Session, Augusta, April 20, 1951.

Many observers note¹ a change in bowel habit as an important diagnostic clue. If the patient is asked about his bowel habits he will give a vague rambling story. But if asked, "when is the last time you had a bowel movement at night", a direct answer will be given. The episodes of nocturnal bowel movements are real to the patient, and most significant to the doctor. Pain as such is not an early symptom of cancer. If there is pain and then bleeding of short duration that usually means an acute fissure or ulceration. In any event, a very thorough search by inspection, by digital examination and palpation must be made. Bacon states that twelve per cent of all malignant tumors of the human body originate in the sigmoid colon, rectum and anus; and that eighty per cent of all intestinal tumors are found in this area.

The average doctor can palpate five inches above the ano-rectal line if he gets the patient to strain and bear down. Over half of the cancers found in the sigmoid, rectum, and anal regions can be reached by the palpating finger. Do not be satisfied with finding a case of hemorrhoids or an anal fissure and saying that it is the cause of the rectal bleeding. An anoscopic and sigmoidoscopic examination must always be done. A means to identify the source of the bleeding in an obvious internal hemorrhoid is to swab out the rectal wall high up through an anoscope and then do an occult blood test on the cotton swab. Again examine the patient after the hemorrhoids or the fissure have been taken care of. Be certain there is no bleeding. A barium enema with air contrast studies may have to be done, and also repeated if necessary. Remember other conditions besides cancer can cause rectal bleeding. Hypertension, blood dyscrasias, nutritional diseases, mucous colitis and diverticulitis must be differentiated.

A new test has been described that will help in making a diagnosis. It is the Bolen² blood pattern test. This test has been used along with and in conjunction with other available clinical data and if used and interpreted carefully, the accuracy approaches 90 per cent. An even more convincing test is the progression of the blood pattern from a two plus positive to a three or four plus positive in six or eight weeks. The Bolen Test must be carefully evaluated and should be used as an adjunct or screening test, not a diagnostic test.

Rectal bleeding with or without pain may be a trivial or it may be the first sign of serious disease. Physicians must carefully examine all patients and cannot be satisfied with having the patient tell you he passed a little blood when he went to the bathroom, and then prescribing a salve or hot sitz bathes. A careful history, physical examination and special studies must be done. If the symptoms warrant, early repeat examinations are indicated and not a reassuring pat on the patients' back. The patient wants good care and advice and his physician must give it to him. A physical examination is not complete without a rectal examination.

Chart 1

BLEEDING PER ANO

1. General Diseases:
 - Blood Dyscrasias
 - Diverticulitis
2. Hemorrhoids:
 - Abnormal Dilatation
 - Redundancy of Mucosa
3. Ulcers about the Anus:
 - Fissures
 - Fistula
 - Ulcer—Venereal Infection
4. Ulcers above the Anus:
 - Sloughs
 - Dysentery
 - Amebiasis
5. Tumors of Ano- Recto- Sigmoid region:
 - Benign
 - Malignant

Chart 2

SYMPTOMS OF BLEEDING

1. Protrusion:
 - Hemorrhoid
 - Polyp—Growth
 - Condylomata
2. Pain: Infection or Irritation
 - Fissure
 - Cryptitis
 - Fecal Impaction
 - Papillitis
 - Fistula
3. Abnormal Stools:
 - Cerebro—Spinal Causes
 - Colitis
 - Dysentery
 - Diverticulitis
 - Malignancy
4. Discharge:
 - Fistula
 - Pilo-Nidal Sinus
 - Pruritus
 - Malignancy
5. No Symptoms:
 - Malignancy
 - Internal Hemorrhoids
 - Endometriosis
 - Blood Dyscrasia

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CAT-SCRATCH DISEASE

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IN 1950, Debré *et al*¹ described a form of benign suppurative lymphadenitis occurring after cat scratches. At the time of this first report, these authors had observed 10 cases of the disease which they called "la maladie des griffes du chat". Several reports of subsequent cases have appeared in the European literature²⁻¹¹. In this country, Foshay studied several cases (unpublished) in Cincinnati as early as 1932, Greer and Keefer¹² have observed a case from Boston, and Lange¹³ has reported the occurrence of the disease in the midwest. Daniels¹⁴⁻¹⁵ has studied extensively several cases in Washington, D. C. Foshay is credited with having first called this entity "cat-scratch fever".

It is the purpose of the present communication to call attention to the occurrence of cat-scratch disease in the South by reporting five cases recently observed in Atlanta and to review briefly the clinical manifestations of this interesting syndrome.

CASE REPORTS

Case 1. A 15 year old white school girl was admitted to Grady Memorial Hospital on September 20, 1951 because of painful glands in the right side of her neck. She was well until 16 days before admission when she noted a painful knot just below the right ear. For about seven days she had anorexia, malaise and low-grade fever without frank chills. During the two weeks before admission she had noted several nontender swellings in the right side of the neck and was treated with five injections of procaine penicillin without effect on her illness. One of the swellings, just above the trapezius, became fluctuant and she was admitted for further evaluation. She denied contact with cats or other pets. Her mother had tuberculosis of the hip. There had been no skin rash or sore throat.

Physical examination revealed normal temperature, respirations, pulse rate and blood pressure. There was no generalized lymphadenopathy. There was a firm, moderately tender 2 x 2 cm. node just below the right ear; just above the right clavicle there was a tender 1.5 cm. node. There was a 4 x 7 cm. fluctuant mass at the upper border of the right trapezius muscle. There was no splenomegaly or rash. The rest of the examination was entirely normal.

Blood Kahn was negative. Urinalysis, red blood cell count and hemoglobin were normal. The leukocyte count was 12,950 with 1 per cent eosinophils, 60 per cent polymorphonuclears, 38 per cent lymphocytes and 1 per cent monocytes. Sedimentation rate was 49 mm./hr. Serum protein was 7.9 Gm. per 100 ml.; formol gel test was positive. Thymol turbidity was 10 units and cephalin flocculation 4+. X-ray of the chest was normal. The

mass in the neck was aspirated and about 10 ml. of yellow odorless pus was removed. Smears revealed no bacteria or acid-fast organisms and cultures were negative. Agglutination tests for brucellosis, tularemia and heterophile antibodies were negative. The second strength PPD skin test was slightly positive; a Frei test was negative.

The patient remained afebrile and without systemic symptoms. There was some subsidence of the cervical adenopathy but other tender nodes appeared, lasting a day or two with tenderness and some redness of the overlying skin, then subsiding slightly. On October 7, 1951, 0.1 ml. of "cat-scratch" antigen (obtained from Dr. W. B. Daniels) was injected intradermally and 48 hours later a positive reaction indicated by painful induration surrounded by an area of erythema was noted. An antigen prepared by heating pus aspirated from the patient's node was employed for a skin test and it too gave a strongly positive reaction. This antigen gave no reaction in 12 normal subjects. Serum protein on October 10, 1951 was 6.9 Gm. with negative formol gel test.

One of the cervical nodes was removed for histologic examination. The diagnosis was granulomatous lymphadenitis, etiology not determined. The patient was discharged on October 12, 1951. At the time of discharge, several firm nontender nodes were still palpable in the right cervical region.

Case 2. A 29 year old housewife was admitted to Grady Memorial Hospital on October 13, 1951 for investigation of left axillary lymphadenitis. About one month before admission she had been scratched on the dorsum of the left hand by her cat. The lesion had become mildly inflamed but healed without treatment. Eight days before admission, she noted soreness in the left axilla which within 48 hours localized to a tender, hot mass about 2 cm. in diameter. At this time, she also noted malaise, mild anorexia and an afternoon fever which reached 103° F. on one occasion. She continued to have symptoms until admission. There was no history of exposure to rabbits or to tuberculosis.

Physical examination showed temperature 99.6° F., pulse 120, respirations and blood pressure normal. There was no rash or general adenopathy. There was a firm, very tender 3 x 3 cm. node in the left axilla. The spleen was not felt. The rest of the examination was normal.

Blood Kahn was negative. Urinalysis, red blood cell count and hemoglobin were normal. Leukocyte count was 8,300 with 47 per cent polymorphonuclears, 51 per cent lymphocytes and 2 per cent monocytes. First and second strength PPD were negative as was a Frei test. Agglutination tests for tularemia, brucellosis and heterophile antibodies were negative. Serum protein was 7.7 Gm., thymol turbidity 0 units, cephalin flocculation negative and formol gel negative. X-ray of the chest was normal. On October 15, 1951, 0.1 ml. of "cat-scratch" antigen was injected intradermally and on October 17 the reaction was strongly positive. The axillary node was removed for histologic examination; the report was granulomatous lymphadenitis.

Case 3. A 9 year old colored male was admitted to Grady Memorial Hospital on October 3, 1951 with a swelling under the right arm of three weeks duration. There was no history of exposure to cats or other animals. There had been no systemic symptoms.

On physical examination temperature was 100° F., pulse 78. The only positive findings were a 2 x 2 cm., slightly tender node in the right axilla, a 1 x 1 cm. right epitrochlear gland and mild splenomegaly.

Blood Kahn was positive, 16 units. Urinalysis, red blood cell count and hemoglobin were normal. A sickle cell

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preparation was negative. Leukocyte count was 8,000 with 4 per cent eosinophils, 1 per cent basophils, 1 per cent juveniles, 58 per cent polymorphonuclears, 34 per cent lymphocytes and 2 per cent monocytes. Agglutination tests for brucellosis, tularemia and heterophile antibodies were negative. First and second strength PPD, Frei and histoplasmin skin tests were negative. On October 8, 1951 Kahn was repeated and was doubtful; the Wassermann test on October 8 was negative. Serum protein was 6.8 Gm., formol gel negative. Thymol turbidity was 3 units and cephalin flocculation was 1+. Blood cultures showed no growth. On October 11 skin test with "cat-scratch" antigen was done, yielding a positive reaction with induration and erythema at 48 hours. The axillary node was removed for histologic study. The pathologic report was "granulomatous lymphadenitis".

Case 4. A white male, aged three, was scratched on the right hand by a cat. The wound healed slowly and about two weeks after the scratch, tender swelling of the right epitrochlear and right axillary nodes were noted. At that time, the patient was febrile (101° F.) and anorexic. There was no splenomegaly. The systemic symptoms subsided after three days but the adenopathy persisted. Laboratory work in the outpatient department of Grady Memorial Hospital revealed normal hemoglobin and leukocyte count, negative PPD, Frei and histoplasmin skin tests, negative agglutination tests for tularemia, brucellosis and heterophile antibodies, and negative blood Kahn.

On October 16, 1951, about five weeks after onset of the adenopathy, a skin test with "cat-scratch" antigen was performed. The reaction was strongly positive at 48 hours. No biopsy was performed. The axillary and epitrochlear nodes were still enlarged, although nontender on October 18.

Case 5. A 57 year old carnival worker was hospitalized for left arm pain. Nine days before admission he awoke with hot, tender swelling at left elbow and in left axilla. He developed fever with chilly sensations, malaise and anorexia. Daily injections of 300,000 units procaine penicillin for six days failed to modify the course of the illness and he was admitted for further study. He had been exposed to numerous domestic animals, including cats, at State Fairs but recalled no scratch or other trauma.

Physical examination showed normal temperature, respirations and blood pressure. The patient was deaf. There was no rash or general adenopathy. The liver was palpated at the costal margin. The left epitrochlear node was enlarged and tender with redness and heat of overlying skin. The left axilla contained several hot, tender nodes, one of which was fluctuant.

Red blood cell count, hemoglobin and urinalysis were normal. Leukocyte count was 2,850 with 73 per cent polymorphonuclears, 20 per cent lymphocytes, 6 per cent monocytes, 1 per cent eosinophils; sedimentation rate was 43 mm./hr. Agglutination tests for brucellosis and tularemia were negative. First strength PPD, coccidioidin and histoplasmin skin tests were negative. A chest x-ray showed emphysema. Thymol turbidity test was 9.2 units; cephalin flocculation was 4+. On the sixth hospital day a skin test with "cat-scratch" antigen was done. This was positive as indicated by an area of erythema and induration 1.5 cm. in diameter surmounted by a small vesicle.

The patient was treated with 1 Gm. streptomycin daily with improvement in general well-being but little change in the lymphadenopathy. He ran an irregular daily fever to 100° F. during the first week but became afebrile and asymptomatic thereafter, although adenopathy persisted and was still present 14 days after admission.

Discussion

In about 60 per cent of reported cases a history of contact with cats has been elicited. In other instances exposure to other animals, occasionally birds, has been described and there is a group in which the disease agent was apparently introduced by other minor

traumata such as thorns. As in Cases 1, 3 and 4, the inciting trauma is sometimes not apparent. Occasionally there develops a small pustule at the original site but the lesion is usually insignificant. The period of incubation between introduction of the agent and the appearance of lymphadenitis varies from five days to as long as six weeks. There may be mild malaise with low-grade fever for a few days, but systemic manifestations are usually mild. Occasionally an exanthem of the erythema multiforme type may occur during the febrile period; erythema nodosum has been mentioned.

The clinical character of the lymphadenitis is variable. The inguinal, epitrochlear, axillary or cervical nodes may be involved with firm swelling of the individual nodes without the matted type of adenopathy so common in tuberculous lymphadenitis. Tenderness is usually present and there is a tendency for redness and heat to appear in the overlying skin, probably due to peridentitis. Occasionally a node breaks down and spontaneous drainage of a bubo may occur. Fistula formation is not uncommon; such draining sinuses heal rapidly. Tenderness subsides after a few days, but the nodes may remain palpable for as long as three months. There may be a slight generalized lymphadenopathy with the disease. Splenomegaly is not the rule, but, as in Case 3 moderate enlargement may occur.

The laboratory findings in cat-scratch disease are not conspicuous. The leucocyte count may be as high as 16,000 but is usually normal. Leukopenia may occur (See Case 5). Sedimentation rate is normal or moderately elevated. It is of interest that Case 1 showed elevation of serum globulin (positive formol gel) early in the disease with return toward normal on recovery, as occurs in lymphogranuloma venereum. In Case 3 the disease apparently provoked the development of a false positive serologic test for syphilis.

The only specific diagnostic test available at present is the skin test, using an antigen prepared by heating pus aspirated from a bubo. The reaction obtained after intradermal inoculation of this material is of the tuberculin type, with erythema and induration appearing 24-48 hours after intradermal injection. European cases have reacted with positive tests to antigen prepared from patients in this country.

The histologic picture of the excised node

is that of a granuloma with micro-abscess formation.

Diseases to be considered in differential diagnosis are tuberculosis, lymphogranuloma venereum, infectious mononucleosis and tularemia. Because of the indolent character of the adenopathy, which may last for as long as three months, Hodgkin's disease or lymphosarcoma may also be suspected. The tuberculin skin test, the Frei test for lymphogranuloma venereum, specific agglutination test for tularemia, the heterophile agglutination test and the absence of typical hematologic findings are helpful in ruling out these causes of adenopathy. The ultimate complete subsidence and the histologic picture on biopsy rule out the lymphomas. Cat-scratch disease should be suspected in all cases of prolonged regional adenitis, especially if a history of exposure to cats is elicited; however, the occurrence of the disease without such exposure is to be emphasized.

The specific etiologic agent in this disease has not been identified but it is thought to be a virus, perhaps related to the lymphogranuloma-psittacosis group of viruses. Extensive studies in this country and abroad have failed to isolate the agent, however.

Since the course of the disease is invariably benign, specific therapy is not of great importance. French physicians suggest that aureomycin may shorten the course of the disease; recently, terramycin has been reported to be efficacious. Penicillin and streptomycin are probably completely ineffective.

Summary

So-called "cat-scratch fever" is a subacute suppurative lymphadenitis which often, though not invariably, follows exposure to cats. Local manifestations with adenopathy, bubo formation and draining sinuses are striking; the systemic manifestations are

usually slight and transient. The disease is probably due to a virus, although no specific agent has been isolated. Pathologically the lesion consists of a granulomatous lymphadenitis with abscess formation. The diagnosis is established by skin testing with antigen prepared from aspirated pus. The course is benign but may be prolonged. Aureomycin and terramycin may be effective in therapy. The present report calls attention to this disease by describing five cases seen within a short period of time in Atlanta, and briefly summarizes the clinical manifestations of this syndrome.

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GEORGIA PRESS COMMENT

A writer whose business is to keep in touch with national affairs has said, "Today in Washington circles that formerly advocated Compulsory Health Insurance, it is considered the height of impropriety even to mention it."

What has caused this rather remarkable about-face in political circles that keep their ears to the ground and their eyes on the voter? The American people, taken as a whole, want no

part of socialized medicine, political medicine, or any kind of medicine that would be under government domination.

This isn't because the American people believe medicine is perfect. It is because they believe progress can best be made under the present free system—and because they are impressed with the immense strides forward that have already been taken.—*Vidalia Advance*.

Special Articles

COCCIDIOIDOMYCOSIS: REPORT OF A CASE IN GEORGIA

FRANK H. STUBBS, M.S.,* and J. LEONARD DIXON, M.D., Albany

The occurrence of coccidioidomycosis in the United States is limited almost entirely to the arid regions of the Southwest (San Joaquin Valley in California and areas in Arizona, New Mexico and Texas). Even in those areas occurrence of progressive coccidioidomycosis (coccidioidal granuloma) is comparatively rare.

The case of coccidioidomycosis reported here is of interest for a number of reasons. To our knowledge it is the first case reported in a resident of Georgia. The infection apparently was acquired during a brief visit to California in 1930 and remained unrecognized over a period of many years.

HISTORY

Mrs. B. lived in Bainbridge until 1929 when she went to New York City. In 1930, she visited in California for a month, spending most of the time in Hollywood, but also a short while in the Mojave Desert. Following this visit she returned to New York State where she lived five years before returning to her home in Bainbridge.

In 1934, Mrs. B. developed respiratory difficulties of an asthmatic type and also experienced pains in her feet, joints and lumbar region. In 1937, she developed a chronic non-productive cough. Symptoms referable to the upper respiratory tract gradually became more persistent and in 1945 and 1946 bronchograms were made. Films in 1945 showed some evidence of infiltration of the right middle lobe and the lower portion of the upper lobe. The film made in 1946 showed definite bronchiectasis of the right lower and middle lobes as well as some thin-walled cavities of the upper portion of these lobes. Her physicians thought that she had tuberculosis. Shortly thereafter she went to Arizona in an effort to regain her health. Her general physical condition improved during that visit and she gained weight.

While in Arizona she did some traveling in a station wagon and was exposed to dust on several occasions.

In August, 1949, Mrs. B. suddenly developed dyspnea which became progressively worse and she was hospitalized and treated for primary atypical pneumonia. Penicillin, sulfadiazine, aureomycin and streptomycin were administered. After eleven days she was allowed to go home, but

almost immediately thereafter her temperature began to rise and continued to do so until the fifth day when she began to have chills. She was again hospitalized. A bronchogram made at that time showed very definite thin-walled cavities. She remained in the hospital for a period of three weeks. Her illness during that time was characterized by marked dyspnea, tachycardia, occasional non-productive cough, and intermittent drenching sweats. On five occasions a light amber colored fluid was aspirated from the right thoracic cavity.

Mrs. B. came under our observation for the first time on November 3, 1949 when she was admitted to a hospital in Albany.

PHYSICAL MANIFESTATIONS

Physical examination revealed a poorly nourished, white female, aged 42. Respiration was rapid and ordinary conversation caused dyspnea. The pulse rate was above 150 and the blood pressure was questionably 85/65. The right chest was dull and breath sounds were diminished. Above the level of the second rib there was an area of hyper-resonance. The liver was markedly enlarged and tender.

X-rays of the chest suggested a hydropneumothorax which almost obliterated the right lung. The right chest was aspirated several times and portions of the fluid were sent to the Albany Branch Laboratory of the Georgia Department of Public Health for study. Tuberculosis or coccidioidomycosis was suspected.

LABORATORY STUDIES

The aspirated fluid was very cloudy, slightly amber in color, and after a short period, showed a heavy grayish precipitate. Repeated examinations of the precipitate failed to reveal acid fast organisms. No bacteria were seen in the smears stained by Gram's method. Moist preparations under a thin cover glass showed non-budding, spherical, thick-walled structures containing numerous endospores which resembled the spherules of *Coccidioides immitis*.

The grayish precipitate was inoculated onto several tubes each of Lowenstein's and Sabouraud's media. After ten days at room temperature a moist, membranous colony was observed on one of the Sabouraud's slants. A week later an abundant cottony aerial mycelium could be observed growing from the colony. On microscopic exam-

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ination the colony showed branching, septate hyphae which broke up into numerous thick-walled, oblong arthrospores. The organism, in all its phases, presented the typical characteristics of *C. immitis*. After twelve weeks' incubation at 37°C. the Lowenstein medium showed no colonies of tubercle bacilli.

COMMENTS

The time at which Mrs. B. acquired her infection with *C. immitis* is not clear. The fact that she developed respiratory difficulties four years subsequent to her visit to California in 1930 suggests that she may have acquired her infection during her stay there. The later visit to Arizona in 1946, with a history of exposure to dust, introduces an element of doubt as to the date of infection, but the long history of respiratory symptoms which preceded that visit suggests prior infection. There was no evidence to indicate that the infection might have been acquired through indirect contact of any type.

The long period of time during which the nature of her illness remained unrecognized illustrates the ease with which this disease may be confused with more common respiratory infections and the importance of the laboratory as an aid in diagnosis.

At the time of this writing (May, 1951) the patient's condition remains about the same. She is able to breathe somewhat easier, sleeps much better and can walk a short distance.

Summary

A case of progressive coccidioidomycosis (coccidioidal granuloma) is described. To our knowledge this is the first case reported in a native Georgian, except in returned veterans.

Evidence is presented relating to the source of infection, the long period of time during which the disease was confused with more common respiratory infections, and subsequent identification of the infection by laboratory methods.

REPORT OF CANCER PROGRAM OF GEORGIA CHAPTER OF AMERICAN COLLEGE OF SURGEONS—AUGUSTA, OCT. 18, 1951

Cancer Commission, Medical Association of Georgia

The Cancer Symposium arranged by Dr. Hoke Wammock for the meeting of the Georgia Chapter of the American College of Surgeons in Augusta was a most interesting and instructive program.

On the panel to discuss the cases presented our eminent guests from outside of the state were: Dr. Alton Ochsner of New Orleans, Dr. Ralph M. Caulk of Washington, and Dr. Julian Johnson of Philadelphia. In addition to these, Dr. Calvin Stewart, Dr. E. R. Pund, and Dr. Stephen W. Brown from our own state were also on hand to join in the discussion. Dr. Enoch Callaway was moderator of the program. Eight varied and interesting cases were presented and discussed in detail by the panel.

During the discussion, it was brought out that while numerous lesions could be treated equally as well by surgery or by radiation, that usually it was necessary to decide in advance which method was to be used and to push this method to its fullest extent and not depend upon one method taking care of the deficiencies of the other. In other words, if surgery was to be performed, the surgery should be as radical as possible. Or if x-ray was to be used, a full complete treatment by x-ray should be given. Incomplete surgery plus inadequate radiation should never be considered as an acceptable method of treating any cancer.

Dr. Alton Ochsner spoke at length on the subject of carcinoma of the stomach and brought out the fact that when a positive diagnosis could be

made of carcinoma of the stomach that as a general rule the cure rate was bound to be tremendously small. He stated that complete gastrectomy was not the answer to the problem. Although he thought that at times a complete gastrectomy should be performed, he felt that the line of lymphatic spread from the lower portion of the stomach did not tend to be upwards, but rather into the gastro-hepatic and gastro-colic omentum and along the vessels to the base of the coeliac axis, and that these structures should be more carefully dissected and removed. He felt that any gastric trouble which did not clear up promptly under medical treatment was entitled to an exploratory operation and in all probability to a partial resection of the stomach with removal of the gland bearing areas. He stated that he felt that this was the only way in which the problem of gastric cancer could be solved. This is certainly in line with the majority of thought about this disease at the present time.

Dr. Pund, in discussing the pathology of one of the cases presented, brought out the little appreciated fact that the pathological grouping according to the number of mitoses present per high field was not as important as had previously been considered. It does not make so much difference whether the group is 1, 2, 3, or 4. The vital factor in any slide is the presence or absence of perivascular lymphatic permeation. When perivascular lymphatic permeation is present, the prog-

nosis is very grave, as the chance that this tumor has already metastasized to the distant areas is very likely. In a recent review of cancers of the breast in one of the state aid clinics, it was found that no case without regard to either the stage or the group had survived five years when perivascular lymphatic permeation was present. This has also been found to be true of cancer of the rectum. The presence of this finding should be very seriously considered both by the pathologist and the surgeon. It is possible that after further study of this prognostic sign in cancers of the breast that we may materially alter our viewpoint as to when radical surgery should be performed and when these patients should be treated with irradiation. At the present time, however, radical surgery must be used in all cases of cancer of the breast, except where the advanced stage makes its use prohibitive.

These cancer symposiums with the presentation of varied cases and panel discussion by men who have a wide knowledge of cancer offer an opportunity for learning more about cancers in a very short period of time than any other type of program that can possibly be presented. The discussions are very varied and always seem to strike at the very vital points in each case. Whenever these programs are presented, all doctors who can possibly attend them should make an effort to do so. Only by improving the knowledge of both the medical profession and the patients about cancer can the mortality from this disease be materially reduced.

AMA REVEALS KREBIOZEN'S FAILURE AS A CANCER CURE

The Committee on Research of the Council on Pharmacy and Chemistry of the American Medical Association recently reported that trial of krebiozen, the so-called cancer drug, "fails to confirm the beneficial effects" claimed last March by Dr.

Andrew C. Ivy, Chicago physiologist and vice-president in charge of the professional schools of the University of Illinois.

The committee's long-awaited report was made after a thorough investigation of the drug, which is said to be extracted from horse serum after the horses have been inoculated with an undisclosed substance. The drug, described as a white powder soluble in water, is alleged to have been discovered about three years ago by Dr. Stevan Durovic, former Yugoslavian physician, who is now living with his brother, Marko, an attorney, in Kenilworth, a Chicago suburb. Dr. Durovic came to this country from Argentina.

The Committee on Research summarized the lengthy 42-page report in these conclusions:

"1. Case histories of 100 patients with cancer treated with a secret remedy krebiozen, were obtained from seven independent sources. These histories were carefully reviewed by a subcommittee.

"2. Ninety-eight patients were reported as failing to show objective evidence of improvement.

"3. Two patients showed some evidence of temporary improvement coincident with krebiozen therapy. In one patient, this was apparently fortuitous; in the other, the major lesions showed continued rapid progression.

"4. Forty-four of the 100 patients treated have expired up to the time of the writing of this report.

"5. Krebiozen failed to show any discernible histologic (minute changes of a cell observed under a microscope) effect upon tumor in the group of patients from whom serial biopsies or autopsy specimens were obtained.

"6. These findings fail to confirm the beneficial effects reported by Dr. Ivy and his associates."

The committee's document stressed the fact that the American Medical Association was making the report as a public service.

DOCTOR C AND SONS

Pioneer Physicians of Georgia

J. CALVIN WEAVER, M.D., Atlanta

In October 1799 a boy baby was born on a river farm in the Abbeville District of South Carolina. Throughout the story of his life in *Echoes from the Battlefield, or Southern Life During the War*, by Noble C. Williams of Atlanta, Ga., published in 1902, he was referred to only as Dr. C—and his identity was never revealed. He lived on the Savannah River farm until early manhood. No doubt the farm life was good training for his later years, when he was destined to become a physician. It might have been expected that the work and chores of farm life would

develop a strong physical constitution and would have but for the fact that he contracted "swamp malaria", as it was then called, bringing about a delicate constitution. Despite this, he had a strong, virile brain, fired with ambition and determination. He inherited the type of cell that tends toward longevity and also the will to do, as he was closely related to one of the greatest statesmen that South Carolina or the South even has ever produced.

His parents must have been thrifty for "by hard study at the best of schools he had been

pronounced one of the most classical of scholars." Graduates in those days were required to submit a thesis written in Latin.

Having decided to make Medicine and Surgery his profession, he proved his determination by setting out on horseback to ride all the way from his home on the banks of the Savannah River to Philadelphia, where he was to attend the Jefferson Medical School. To look back over one's shoulder for a century and a half, 'twill be difficult to realize just what such a ride would mean; a rough, broken and sparsely settled country, hostile Indians roaming around and wild beasts a constant menace, not to mention bad weather conditions at times to be encountered. At Jefferson he pursued his studies diligently, and in due time obtained the "glittering prize" which fitted him to proficiently practice as Physician and Surgeon.

Fortunately, his stay in Philadelphia improved his health greatly. He returned home on horseback in the full strength of vigorous manhood, a happy young man.

Returning home, he naturally gave considerable thought to the subject of his future home and finally decided on Elbert County, Georgia. His practice soon extended over Elbert County and into the adjoining county of Wilkes. One of the friends he made in Wilkes was instrumental in shaping his destiny. He was a quaint middle-aged Irishman by the name of Ned Malalley.

He introduced Dr. C to his future wife in the following manner: "Miss Lucy, allow me the pleasure of introducing to you, my young, handsome and greatly esteemed friend, Dr. C., and it is a great pity he drinks, _____ water." This turned out to be an old case of love at first sight. Miss Lucy's father was a farmer of means, also sheriff, and it was at his beautiful, old-fashioned southern country home, that Dr. C and Miss Lucy were eventually married. After the ceremony, they all repaired to the snowy tables, which fairly groaned under the weight of the good things to eat.

The narrative by Williams always referred to Dr. C's wife as 'Miss Lucy.'

A short time prior to his marriage, Dr. C had taken a trip to the then busy little town of Decatur, Georgia, and was so favorably impressed he decided to move from Elbert County to Decatur. He purchased a beautiful, large lot with a small plain cottage at a very low price, as his means were very limited. With his innate honesty, he had apprised Miss Lucy and her family of his financial status. Her family offered to give them a nice start but his pride caused him to courteously decline. How different from the young couples of today.

They traveled by private conveyance half of one night and nearly a full day before reaching Decatur. They spent a few days at the little inn, while furnishing the cottage preparatory for their occupancy.

He rapidly worked into a typical country practice which kept him away from home a considerable part of the time. Though alone a great deal, his wife kept busy with household duties and outdoor work, improving the yard.

The people of Decatur were highly cultured and readily took Dr. C and "Miss Lucy" into their circle. In a year, a little baby boy was born and was named John C., in honor of a relative, one of the South's greatest statesmen. In due time, twin sisters came into their home, one named Georgia and the other Carolina, a rather unique idea of Dr. C's.

As the years passed, the following girls and boys were added to the family: Virginia, Indiana, Missouri, Louisiana, Florida, Edward, Pickens and two daughters, who died in infancy. Louisiana also died while a baby. This idea paralleled one of my own great grandfathers who named six sons John Calvin, John Hodges, etc., all John's; and one daughter John Anna, who was called Johanna. My grandfather for whom I was named was Dr. John Calvin Drake of Thomaston. He named his old gray horse John.

When John C. reached man's estate, he was of a tall and commanding figure, was intellectually gifted, acquired a collegiate and medical education and moved to Lee County, Georgia, for the practice of his profession. When in the zenith of his practice, he was stricken with a tumor, to which he eventually succumbed, bringing the first great sorrow to his father's family. Of all his connections, none felt his loss more keenly than two faithful negro servants, Aunt Ellen and Uncle John.

Soon after the death of Dr. John C., Dr. C moved to the "little village" of Atlanta, six miles northwest of Decatur, where he lived for many years to watch its marvelous growth from a village to a very important city.

When a resident of Decatur, he had a large practice which extended into DeKalb, Gwinnett and Fulton counties. With his large family, it behooved him to have a large practice though beef was selling at 4½ cents a pound and eggs at 10c a dozen and chickens or fowls, two for 25 cts. and other commodities in proportion.

He moved into Atlanta in 1854. Just why he made the move is not known for at the height of his career in Decatur he was considered the most prominent physician in that section of the State. Several of his prescriptions were put on the market and gained an extensive reputation. Before moving to Atlanta, Dr. C in 1836 commanded a company of infantry in the Creek War. His courage was never doubted and he was exceedingly popular with his men.

Though he moved to Atlanta in 1854, the first record available was the city directory which lists his office at Peachtree and Marietta Streets, the streets not being numbered then. His residence was on the west side of Cone Street, between

Walton and Luckie, both of which are in the heart of the city now.

In 1874, his office was located at 83 E. Alabama. His residence was at 78 Washington Street at that time. He resided in the southern portion of the city in a well appointed two-story house situated on a two acre lot on which was an orchard, vineyard and garden spot, barn, smokehouse, servants' house and flower yard. From the standpoint of worldly goods, at this particular period in their lives, Dr. C and family had nothing to wish for.

Soon war clouds began to threaten; the hot blood of the South became thoroughly stirred up and soon it was decided to secede from the Union and form a Confederacy of its own. Dr. C, a man of strong political opinions, was a Unionist and strongly opposed the dissolution of the Union. As the bugle called for men good and true as volunteers to sustain the newly created government, the sound penetrated the peaceful home of Dr. C, and stirred up the warlike spirit of his two sons, Edward Livingston and Pickens Noble. Edward was one of the first to enlist for military service, but his brother was too young and Dr. C commanded the younger son to remain at home. Dr. C's judgment was in opposition to secession, yet he was firm in his conviction that it was right to repel the North. When his brother, Col. C, who was mayor of the city, requested the citizens to aid in its defense, promptly Dr. C reported at the mayor's office with his musket and knapsack, ready to go into the trenches. His son, Edward, joined Company B, Fulton Dragoons, a cavalry company organized in Atlanta. Edward was an accomplished musician and acted as bugler for his company. He was assigned to serve under Gen. Wade Hampton, then stationed in Virginia. As Edward was a skillful physician and surgeon, he was placed in charge of an ambulance to drive over the battlefield and bring in the seriously wounded. Though having narrow escapes, he was never wounded; his closest call came when an exploding shell tore off the greater portion of the top of his ambulance. Pickens Noble, who had enlisted later, died while still in service, apparently of pulmonary tuberculosis, and was buried in Hollywood, a beautiful cemetery of Richmond, Va.

When Gen. Wm. T. Sherman was pressing on towards Atlanta, Dr. C was largely interested in one of the principal drug stores of the city and was compelled to take over the management as his partner and clerks were called to enter the army. While serving as surgeon to Col. Stiles' regiment, he was forced to retire on account of ill health, brought on by overwork and by drinking impure water on the island of Skidaway. Later on, Dr. C was seriously ill and had been attended by his wife's nephew, Dr. John Whitworth, who was the last Southern surgeon to leave the city.

Fortunately, a young northern soldier came to his door and asked permission to pick some grapes.

His request was granted; on account of Dr. C's serious illness, the young soldier was asked to have a Federal surgeon visit the doctor; in response, Dr. Wm. C. Bennett called upon the doctor and found him very ill, suffering with a dangerous tumor on the side of his face. An operation was performed and Dr. C regained his health after many weeks of convalescence. Unfortunately for the doctor, his entire stock of drugs, notes, accounts and valuable papers all went up in smoke as the result of Sherman's orders.

Having regained his health, Dr. C was elected mayor to serve until the return of the mayor who had gone south after surrendering the city. One of the doctor's first official acts was to appoint every able-bodied man a police officer to protect the citizens from the plunderers who had invaded the city in large numbers.

Soon after the surrender of General Lee at Appomattox, Dr. Edward C returned to his home, footsore and tired. He was appointed city physician, the first Atlanta ever had; daily as well as nightly, he was called on to minister to the indigent poor, both white and black, and as small-pox was an epidemic, his position was not an enviable one; tiring of this work and being well versed in civil engineering, he obtained the position of assistant engineer on the Atlanta and Charlotte Air Line Railroad, the first one surveyed after the close of the war. This job finished, he resumed the practice of medicine. Preferring a country practice, he established in Henry County and was so successful that he earned the sobriquet of 'meningitis doctor'. He soon married and a baby girl was born to them, "The idol of his heart", but the little girl died in early childhood. While the baby yet lived and was a source of much happiness, his health began to fail and he decided to give up country practice. He soon removed to Decatur, Ga., where he had first seen the light of dawn. He had apparently recovered from a serious attack of pneumonia, which had been brought on by exposure during the winter season.

His cough, however, assumed a serious intensity and it was feared that consumption was making inroads upon his once vigorous constitution. He was persuaded by his father and mother to come and live with them in Atlanta. As frequently happens, he passed away at dawn, probably August 9, 1874, as he was buried August 11, 1874.

Less than a year after, Dr. C was stricken with pleuro-pneumonia. Though he had passed his seventy-fifth mile-post, his vigorous manhood allowed him to stubbornly resist this attack, attended with much suffering, for twenty-seven days, when death came as a relief to him. He died March 13, 1875. Funeral services were held at the Central Presbyterian Church in Atlanta. He was buried in Oakland Cemetery, just a few steps from the grave of our illustrious and beloved Margaret Mitchell and not far from the Confederate monument. There side-by-side rest the bodies of Dr. C,

his wife, and their son Edward, together with grandchildren and great-grandchildren. If you should visit Oakland Cemetery, you will find the following enlightening inscriptions:

Dr. E. N. Calhoun
Born Oct. 1799
Abbeville District, S. C.
Died March 13, 1875.

Lucy B. Welborn
(Mrs. E. N. Calhoun)
Born April 9, 1808
Wilkes County, Ga.
Died Feb. 11, 1882.

Dr. Edward Calhoun
Born Dec. 23, 1836
Died Aug. 11, 1874

In the Atlanta Constitution under date of Sunday, March 14, 1875, there appeared a fine editorial sketch of the life of Dr. C and a tribute to him. In part it says, "he followed for fifty years his profession. He ever seemed to appreciate the responsibilities of his profession and to feel that

it demanded the constant exertion of the noblest faculties of his mind and heart."

Though a great sufferer during his illness, when the appointed hour came he seemed composed and free from pain. We hope that he passed away quietly and calmly as the last lingering stars from the twilight of morning pass into the brightness of the perfect day.

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2. The Atlanta Constitution, March 14, 1875.
3. Dr. John C. Calhoun, son of Dr. E. N. Calhoun, practiced medicine at Starkesville, Ga. He died at the age of 25 years in Starkesville and was buried there.
4. Mrs. G. D. Moreland, Sr., Leesburg, Ga. from records at the cemetery in Starkesville, Ga., and from the tombstone at the grave of Dr. John C. Calhoun.

Note: Since this paper was written, a letter from Jefferson Medical College states that there is no record of Dr. E. N. Calhoun ever having attended Jefferson Medical College.

A letter received later from the University of Pennsylvania states that there is a record of an E. N. Calhoun of South Carolina matriculating at the University of Pennsylvania, but that they have no record of his having graduated.

FREEDOM FROM GOVERNMENT

ELMER HESS, M.D., Erie, Pa.

I should like to tell you a baseball story. Years ago, when Walter Johnson was in his prime and Gabby Street was his catcher, an interesting situation developed in a game between Washington and Philadelphia. You know in those days along toward the end of the game the balls used became very much scuffed and dirty. You did not get a new ball every time a flaw was found, and there were no lights in the parks. Many a game had to be called on account of darkness. In this particular game, it was the last of the ninth inning. The score was 3-2 in favor of Washington, a man was on second and one on third, two men were out, and Walter Johnson had two strikes on a rookie by the name of Jimmy Foxx. Silk O'Laughlin was umpiring for probably the last season because of his age and perhaps his eyesight. Street, because of the darkness and the badly discolored ball, had almost missed the second strike. It must be remembered that, in those days, Johnson had blinding speed. Street had an idea. He walked out to the mound and said, "Walter, I almost missed that last strike. A passed ball means a tie game and they say this young Foxx is a terrific hitter.

If he gets hold of one—goodbye game. Now, I'm going to hide the ball in my glove. You go through the motions of throwing your fastest one, and I'll clap my hands across the center of the plate, show O'Laughlin the ball. He's getting a bit blind, and maybe we can get away with it."

Walter agreed.

Street went back to his position, crouched over, and gave his signal. Walter went through the motions of pitching. Street clapped his hand against his glove, held up the ball, and O'Laughlin yelled, "Strike three, you're out."

As Street walked toward the dugout, he heard Foxx say with complete disgust, "Why, you blind old so-and-so, that damned ball was a foot outside."

As I speak, I should like you to remember this story.

I should like now to talk to you a few moments, if you will listen, and take you back to the time when our forefathers came over here. They came to escape from Government. There had been so-called democracies, there had been so-called dictatorships, and other forms of government since the beginning of time, but always the man, or group of men or family, or families of the groups of men, who took power in government had had little to offer the average man. Government was important, whether it was called a dictatorship,

Speech delivered by Dr. Elmer Hess, President of the American Urological Association, on Oct. 18, 1951 at the annual convention of the Georgia Chapter of the American College of Surgeons at the Bon Air Hotel, Augusta.

democracy, republic, or what have you. You have only to recall the history of your own schooldays to realize that only those who were in power found favor and the common man was always the loser. The ordinary man was always the one who suffered and who never benefited from government. Then—something very unusual happened. Your forefathers and mine came to this country to escape from government—yes—TO ESCAPE FROM GOVERNMENT. They came over to this country; they made their farms; they developed manufacturing; they became very, very independent as individuals, and for the first time in the history of the world, the average man, the common man, found his place as an individual. They demonstrated that they would not accept taxation without representation in Boston Harbor. They wanted to have something to say about how their money, which they paid to the government in the form of taxes, was going to be spent. They refused to pay taxes and allow their money to go across the ocean to the British Empire and be spent as the King wanted to spend it without due consideration to the needs and benefits of the men who made the money to pay the taxes. So a war was fought, and again it was a revolution. Again, it was a revelation of courage.

After the war, a group of fiercely independent individuals from the Thirteen Colonies on the Eastern Seaboard got together, and they were so violently individualistic that they couldn't agree upon anything. A few of the cooler heads got together and wrote the Constitution which declared that all men were free and equal. Now, that freedom and equality did not mean that men and women were born equal, or that they were to have equal fortunes, but that they should have equal political rights. That is all it meant. And that meant that an individual was important and government was relatively unimportant.

Then, our forefathers elected a president of the United States and he was given a reception in New York. These representatives of each colony who were in New York for the reception and inauguration discussed how they should address the new chief executive. Should it be "Sir", "Your Excellency", "Your Lordship", "Your Honor", etc.? Again, that fierce individualism came to the forefront, and one chap said, "I'll call him 'Mr. President' and nothing else", and the President of these United States became "Mr. President" from that day to this.

While our Constitution was being discussed, Mr. Washington made the statement that unless the Constitution was written in ink, and written that day in ink, according to the suggestions that had been submitted—that tomorrow this Constitution would be written in the blood of the people of this new country of ours. He knew that the people would refuse to accept anything that did not give them freedom from government.

Thomas Jefferson happened to be in Europe

at the time the Constitution was written trying to straighten out some of our affairs with France. When he arrived home and read this Constitution, he remarked that these men have written better than they think. He recognized that this Constitution must be implemented and that without implementation it was worthless. So, he wrote the Bill of Rights. That Bill of Rights implemented the Constitution; that Bill of Rights has been a sacred instrument all this time until a few years ago. This country has grown great, for each individual in it had political freedom and was an individual, and the individual was the only thing that counted. I think it was Jefferson, the Democrat, who said that the least government is the best government.

Now, there are some very important things that have taken place in this world of ours, and we have been seeing them all happening in the last few years. I would like to call your attention to two or three of them. The scientific men, you know, recognize it as true that if one puts a substance here and a substance there together, the chemical reaction is always identically the same. If one puts food in one's stomach, and one has a normal stomach, the chemical reaction is identically the same. Everything in nature is bound by certain specific rules. The very fact that our scientists have been able to crack the atom has proven that chemistry and all of nature's reactions are identical under identical conditions. Only one thing in all this world is different, only one. If one plants an acorn, one gets an oak. One plants a sperm and it contacts an ovum in the proper place, one gets another human being. Reaction is always the same, but the human being has something which is completely contrary to all nature, his mind. He can make a choice as to which road he will take. He can say, "I'm going this way, or I am going that way." He can go any way he chooses, but by reasoning that one direction is the better way to go, he may take it. That is the thing that has been given to you and me by Almighty God. That is the thing which makes of us creatures with spiritual values; that is the thing which makes of us human beings made in the image of our God; and no other animal or other thing in all of nature has that power. Have we forgotten it? Yes, we have forgotten it, but our forefathers realized that they could accomplish anything with faith in Almighty God.

A lot of people have said to me, "Why are you fighting Socialized Medicine?" I'm not fighting Socialized Medicine, ladies and gentlemen. I'm fighting Socialism. I'm fighting materialism; Socialized Medicine is just one small part of the whole picture. I believe that in fighting Socialized Medicine—if we have the concept of the overall picture—we will again dedicate ourselves to the principles of government which stimulated our forefathers to come over here, face the jungle, and the savage, and create for the first time in the

history of all this world a government of the people, by the people, and for the people, as Abraham Lincoln said. Then the individual becomes most important and the government least important. That is what you and I regard as the principles of our forefathers. We must destroy, if we possibly can, the socialistic trend which is so rapidly involving us, and which will completely destroy us unless we have the courage of our convictions and rededicate our lives to the principles for which our forefathers came over here; i.e., freedom from government.

You and I have a job to do. You and I do not realize it perhaps because we know our own weaknesses and our own limitations. You and I occasionally like to have a drink and sometimes do other things that we know we should not do. For the most part, doctors are not preachers. They often do a lot of things they would be ashamed to have any one else know they did—there is no question about that—but their patients idolize them. To their patients, they are gods. Believe it or not, ladies and gentlemen, a doctor is a god to the mother whose child he saves, or she thinks he is. You and I can spread the message to our patients that this vile thing called Socialism, which is only the first cousin of Communism and godless materialism, must stop NOW, and you and I can stop it. I do not care whether you are a Democrat or a Republican, I can take a Carter Glass, or a Byrd, yes, and I can take a Bob Taft or an Eisenhower, but I no longer can take that which we have today in Washington and which is called an American Administration. We are being sold down the river. There are few people who know what we are getting into, and I am sure that they do not realize how far the socialistic trend has gone. There is only one thing that matters in Washington, and that is the Almighty Dollar. We have to start thinking, talking, and working. We

have to convince our own doctors that the Almighty Dollar is not the important thing, and I am sorry to say some of them do have that idea. This is a hangover from the examples we have had in Washington. Thank God for MacArthur and many others who have the courage of their convictions, who are God-fearing men who cannot be bought, and who speak out what they think is wrong, and who try to warn us. Yes, let us have some freedom from government. Someone is throwing a ball in Washington that is not there, someone is catching a ball in Washington that was not thrown, someone is so blind that he cannot see whether the ball is coming or not, and someone at the plate says it is a foot outside. You and I are supposed to have brains. We, in this country, usually vote our emotions. We are never for anything but are always against something. Can't we vote for something? Now, cannot we say to those men whom we choose to have represent us in City, State, and National government, "Don't try to sell us Socialism or we will destroy you at the polls as we did Pepper in Florida"? Yes, I sent money down to support a man named Smathers, a Democrat, to defeat Pepper. I did the same thing in North Carolina. Do not think for a moment that these people who have taken over the Democratic Party in Washington are your kind of people at all; they do not even belong to you let alone being considerate of you.

Tomorrow may be too late and if this country is destroyed, if democracy goes out the window, if the Constitution of the United States is laughed at and held up to ridicule and you and I permit it, then we deserve the kind of government we are going to get. This will be the vilest type of materialistic dictatorship unless you and I go back to God.

501 Commerce Building
Erie 1, Pennsylvania

POSSIBLE ATOMIC BOMB EFFECTS APPLIED TO ATLANTA

CHARLES E. DOWMAN, M.D., Atlanta

One of the greatest problems in discussion of the Atom Bomb is the problem of fear. All of us have definite fear, particularly about the unknown. It is always less when we know exactly what something is, what effect it may have, etc. We as doctors have always cared for the sick and the injured and will continue to do so. We need education about the Atomic Bomb in order to make it possible for us to work, when such work is necessary on bomb casualties, without being diverted by the fear complex. As a Reserve Officer

in October of 1948 in Washington, the author was fortunate enough to have been allowed to attend a course of intensive lectures and since then has continued to keep up and improve his knowledge by reading.

The Atom Bomb as exploded over Hiroshima and Nagasaki had the force of 20,000 tons of T.N.T. Table 1, taken from the U. S. Strategic Bombing Survey, shows the comparable effects of the atomic bomb explosion at Hiroshima and Nagasaki compared with the explosion of 1667 tons of T.N.T and incendiary bombs on and over Tokyo in one day. It will be noted that the casualty figures are fairly comparable.

Delivered at a special meeting of the Fulton County Medical Society 7:30 p.m. September 14, 1950 at the Academy of Medicine, Atlanta.

Table 1

	Hiroshima	Nagasaki	Tokyo
Population/Sq. Mi.	35,000	65,000	130,000
Sq. Mi. Destroyed.....	4.7	1.8	15.8
Killed or Missing.....	70-80,000	30-40,000	83,600
Injured	70,000	40,000	102,000

Results of single atomic bomb explosions at Hiroshima and Nagasaki vs. a single raid on Tokyo with 1667 tons of H.E. and incendiary bombs. (From U. S. Strategic Bombing Survey).

The bomb itself produces casualties in three ways; by trauma, burns, and irradiation.

1. *Trauma*: The direct blast effect of the bomb on humans was negligible, there having been essentially no casualties at Hiroshima or Nagasaki from direct force. By indirect trauma however, meaning the effect of the bomb being transmitted to glass, walls, etc., injuries were quite heavy. Sixty per cent of the people between 550-1400 yards from the epicenter were injured and the injury rate was slightly less up to 3000 yards, beyond which the rate fell off rapidly, but was still fourteen per cent at 5000 yards. There was the following distribution in one group: Fractures—11.5 per cent, Contusions—53.8 per cent, Lacerations—34.7 per cent. Many of the lacerations were due to fragmented glass which could be stopped by clothing. Most of the deaths from trauma occurred within 2500 yards of the epicenter.

2. *Burns*: Flash burns, or so-called "profile" burns were of no significance beyond 4,400 yards, and few beyond 3,300 yards required any treatment: 53 per cent of the deaths from burns occurred in the first week, 75 per cent of them within two weeks. Ordinary khaki clothing protected beyond 1650 yards but was no protection within the lesser distances. Light colors were more effective in protecting, as was loose, thick, or layered clothing. There were no flame-burn survivors, since within an hour of the explosion each town was afire and those patients who were unable to walk were burned to death.

3. *Radiation Effects*: 85 per cent of the casualties were from burn and blast, there being only 15 per cent where radiation effects were of any importance whatever. These effects were produced from the various forms of radiation which occurred.

A brief word as to the various components of radiation is wise at this time. Alpha-radiation consists of helium nuclei and these are stopped by a few thicknesses of paper. Beta radiation actually consists of electrons and these are stopped by a few millimeters of tissue. Gamma radiation consists of rays like x-rays although more forceful. These may pass through the body without damage but may strike any part of an atom in the body and produce ionization and subsequent damage. Neutrons are relatively large particles usually traveling fairly rapidly and may collide with atoms in the body, producing ion-pairs and consequently continued ionization.

We are fortunate in that the detectable versus the dangerous radiation is in the ratio of 1:10,000,000. As to dosage, the chronic rule of thumb is 0.1 R per day, which is obviously unrealistic in explosion problems. It may well be necessary to accept a larger dosage than this in order to get casualties evacuated from a contaminated area. One must realize that a patient may receive as many as 100 R to the body as a whole, while taking a gastrointestinal series, long-bone, skull, and spine x-rays, without obvious damage. A more realistic exposure-rule is needed in atomic explosion emergencies, with perhaps a maximum dose of 50-100 R per person should contamination be bad. In other words, we may have to "use up" rescue personnel from a radiological standpoint in order to evacuate casualties.

With the usual airburst there is no contamination and no cause for worry for entering personnel after a period of about five minutes at a maximum, even immediately under the epicenter. This does not hold true with other types of explosion where contamination does occur (V. I.).

The median lethal dose, that which produces death in 50 per cent is in the realm of about 400 R. After having been exposed to such dosage the patient develops nausea and vomiting within a few hours, then feels well usually until about the end of the second week at which time loss of hair, general malaise and fever develop, followed by agranulocytic angina around the fourth week with pallor, petechiae and epistaxis. During the fifth week one sees emaciation and rapid death in about 50 per cent. Blood and antibiotics are some help in this group and may save more if properly applied. Aureomycin as a prophylactic seems to do very well but its value over and above other antibiotics after exposure is not definitely proven.

The 100 per cent lethal dose is over 600 R. In these people one sees nausea and vomiting early, diarrhea, various inflammations of skin and mucous membrane, fever, emaciation and death usually within two weeks.

A moderate dose is in the realm of 100-300 R. With this dosage epilation may occur in the third week, malaise and diarrhea in the fourth week and then the patients get well unless they develop secondary handicaps. Blood and antibiotics are of considerable help in this group when indicated. All of the preceding remarks about irradiation have been concerned primarily with external radiation.

Internal radiation can occur only with ingestion of the irradiating chemicals or with wound contamination. "Radiation warfare," ground level, or underwater bursts can produce the situation where internal radiation could occur.

The effects of various bursts should be considered:

1. *Low Level*. The low ground level burst which occurred at Alamogordo, New Mexico was of this type. All radiation products were not carried away

Table 2
MEDICAL PLANNING

Assume one atomic bomb were detonated in the air over a city at height intended to produce maximum physical destruction and assume it would produce 120,000 casualties (killed, missing, injured). Then there would probably be 40,000 deaths on the first day, 20,000 deaths after the first day.

then replenish this at a later date or use the next produced fission products at another place. One of the greatest drawbacks to this use of atomic power is that the effects are not noted for some time. It is therefore a poor weapon from a military standpoint. It is also easily detectable should anyone be sufficiently suspicious to use detection devices.

Ideally the airburst produces the maximum casualty effect. Hence let us follow out and apply to Atlanta the lessons suggested in R. E. Lapp's "Atomic Bomb Explosions—Effects on an American City."¹ He presumes that there will be some gradual improvement in the efficiency of the atomic bomb, such as has occurred, so that the amount of force delivered can be estimated after the developmental period as being about 50,000 tons of T.N.T., compared to the effects of 20,000 tons of T.N.T. which size bomb was used at Hiroshima and Nagasaki. Also it is presumed that the bomb is exploded at the exactly ideal height. In applying this to Atlanta the essayist used a map centered at about Five Points; consequently the accompanying diagram shows for the convenience of the author that the epicenter is immediately over Five Points. The destruction and casualties can then be estimated and the problem for planning purposes thus arrived at.

Figure 1 shows a sketch of the concentric circles of damage estimated. Zone A is within a one-mile radius of the epicenter. Here the damage will be very heavy. All frame and brick buildings will be completely leveled and in the two and a half square mile area there will be only a few reinforced concrete building which stand around the edge as shells. These will be useless. Zone B is from one mile to one and three-fourth miles from the epicenter. This represents six square miles more of the city where damage will be expected to be heavy. There will be a few of the useful peripheral buildings that will have been skipped but most of their interiors will be useless. In zone C, which is one and three-fourth to two and one-half miles from the epicenter there will be moderate damage to frame buildings and houses, light industrial plants will be destroyed but here at least the streets will be clear and one will be able to navigate them. Zone D, which extends to a distance of three and one-half miles from the epicenter will show slight damage except for fires. Before moving your home or place of business you had better make sure our possible enemy has good fusing

methods, good aim, and wants to set off the bomb at this point.

Now let us look over the casualties. In zone A there will be less than 1 per cent survivors. In zone B there will be at least 50 per cent casualties. In the city of Atlanta 185,000 people live in zone A and zone B and 150,000 more work here. There will be no radiation damage outside these two zones. A casualty rate of 120,000 for planning purposes seems far from excessive. What can we expect to happen to them? Table 2 shows expected deaths: 40,000 of these casualties will die on the first day, 20,000 more within the next three weeks. This means then that 80,000 casualties will have to be evacuated and given medical care. The outcome of these 80,000 casualties insofar as hospitalization is concerned is shown in Figure 2. As you can see not all will require hospitalization, but a fair number will, there being still a residuum of 500-1,000 hospital patients even after six weeks.

Certainly if the bomb were exploded today it seems extremely unlikely that we could do better than the Japanese did. Now is the time for us to plan so that we can do better than they did. Let us go back to Figure 1 which shows the expected damage areas. We have remaining as useful hospitals; Lawson Veteran's Hospital, Emory University Hospital, Fort McPherson Station Hospital and the Naval Air Base Dispensary. If transportation is available we would certainly have to evacuate patients to Marietta, Gainesville, Athens, Rome, Griffin, Newnan and other near-by cities.

We would have to assume that 80-90 per cent of our doctors might be ineffectives. There are cer-

Table 3
ESTIMATING WHOLE BLOOD REQUIREMENTS

1. Estimate number casualties expected to survive first day.
2. This figure will represent number of pints of whole blood required during each of the first three weeks.
3. Total requirements will be three times the number of casualties surviving the first day.
4. 250,000 to 300,000 pints may be required if an atomic bomb is detonated in the air over an American city, as at Hiroshima.

ESTIMATING WHOLE BLOOD REQUIREMENTS

1. If 80,000 casualties survive first day
2. Weekly requirements will be roughly

80,000 Pints	80,000 Pints	80,000 Pints
Mainly for burn cases	Decreased needs for burn cases offset by increased needs for radiation sickness cases	Mainly for Radiation sickness cases
First Week	Second Week	Third Week

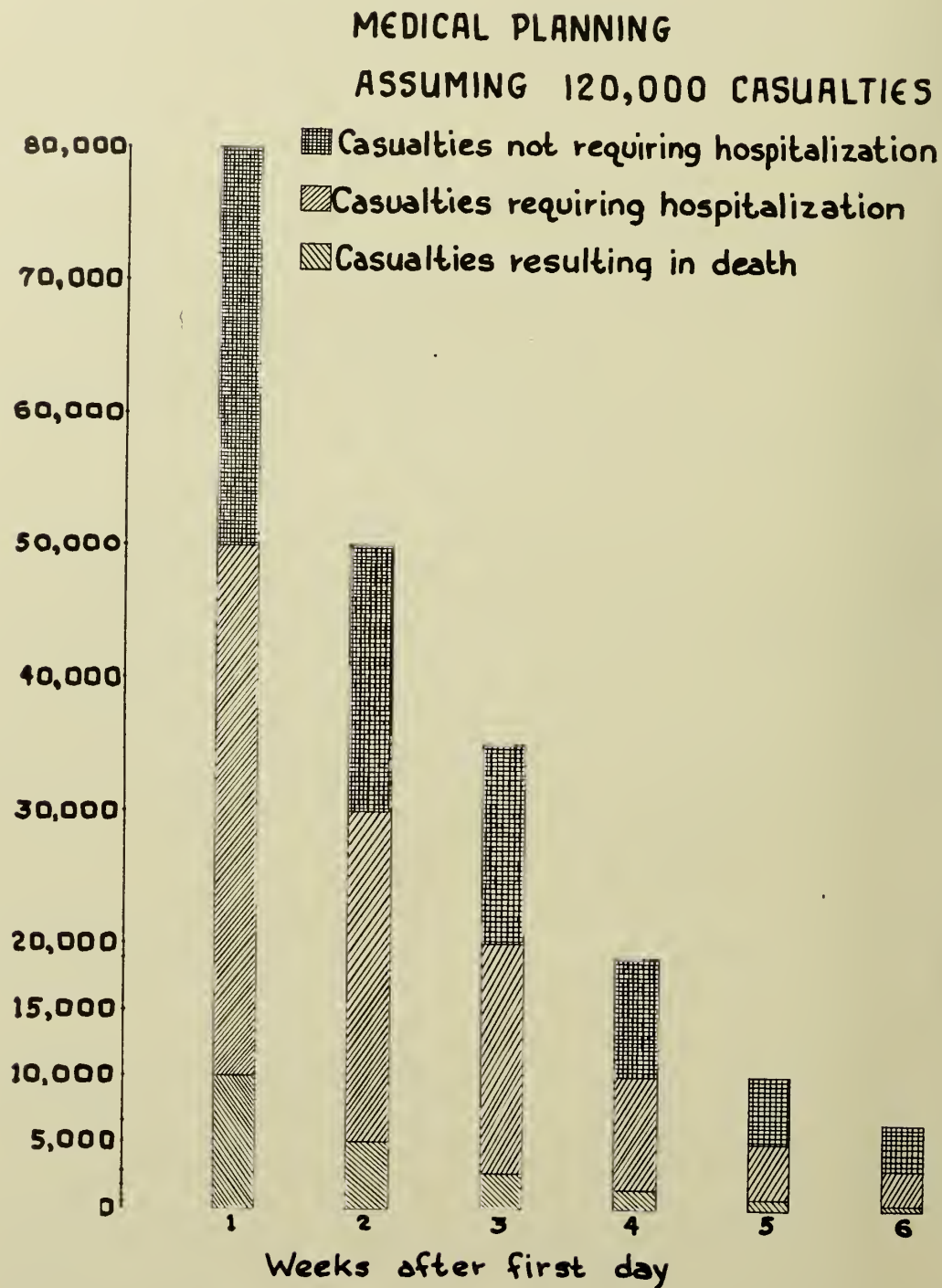


Figure 2.

tain needs that we have when hospitalization is considered. Following are some of them: water, housing, dressings, personnel, transport, communications, roads and guides, blood. In addition we need instruments, sterilizers, etc. The ideal place would have all these things available. Let us look into some of the possible locations.

East Lake Country Club has water, a golf course to land planes on, a fair road net, personnel can be brought from the Divinity School or Agnes Scott College, and buildings and kitchens are available. Brookhaven Country Club likewise has water, the Naval Air Station is nearby for air evacuation, with Oglethorpe University for personnel, and buildings and kitchens already erected. At Emory, using the university buildings for expansion, we have adequate personnel, water within a half mile, and kitchens, although we have no close air field. At Lakewood, buildings and water are available, an air field is about two miles away but it is possible to land a pontoon plane on the lake or a jeep plane on the race track. Personnel from Clark University can be used.

Our blood needs are shown on Table 3 and Figure 2. We would need roughly 240,000 pints over a three week period although our needs might well be as high as 350,000 pints. We must then depend on other cities and fly the blood in. We need to have everyone's blood typing done now rather than waiting until we are in trouble. We should certainly consider tattooing the blood type

on each individual, or furnishing everyone with dogtags. Certain equipment would make this job much easier, hence stockpiling of donor and recipient sets now would be wise. Chemotherapeutic agents as well could be stockpiled and we need the same thing done with burn dressing. A careful standardization of treatment of burns is needed, in order that the average individual can be taught to give first aid and care for burns, inasmuch as we may not have the opportunity of all our casualties being treated by doctors. For blast casualties we need splint materials, operating room supplies and particularly sterilizers. As far as personnel is concerned we need trained teams to carry out all these procedures.

Our help must come from Augusta, Columbus, Savannah, Valdosta, Macon as well as from out of the state of Georgia. Let's teach them as well as ourselves. This is important inasmuch as 95 per cent of the doctors at Hiroshima and Nagasaki were ineffective.

Summary. In considering the problem of the city of Atlanta, one atomic bomb could destroy the core of the city, entirely disrupt our rail network and our entire central organization. We would have 80,000 casualties to treat. Plans to take of these people are needed now inasmuch as organization after the bomb is dropped is too late.

Footnotes—1. Published in The Bull. of Atomic Sc. 1948, vol. 4, p. 49.

MEDICAL AID PLAN FOR CIVIL DEFENSE METROPOLITAN ATLANTA AREA*

**CHARLES EBERHART, M.D., Atlanta

For the past year we have concerned ourselves with the hard facts of devising a method for applying medical aid to the anticipated atomic bomb casualties in the metropolitan Atlanta area. In discussing this subject with any physician unacquainted with the extent of this catastrophe, two reactions are usually encountered. One physician will suggest grandiose plans, economically and physically impossible to execute, while the other will adopt an attitude of extreme pessimism. We must face the fact that should Atlanta be bombed now, we would have to do with what is available at the moment and with what remains undestroyed. No doubt the plan outlined herein can be improved upon or it may be necessary to revise it entirely, but it is a start and it is hoped not a false start. There are many unanswerable questions. For example, how far should we pursue the development of these plans? How self-sufficient should we try to make ourselves locally? Other

cities may be bombed at the same time Atlanta is hit. If this occurs, will adequate transportation be available to evacuate our casualties needing definitive care in distant organized hospitals?

In devising plans which involve such a huge problem as confronts us, any new proposal while reasonable and desirable on first thought, may be found to be beyond solution when put under careful scrutiny.

With this disaster, all services are going to be inadequate. Many injured are going to die because of the physical impossibility of bringing together everything needed at the right moment. All of us must face this fact.

There is reason to believe that an enemy would attack at noontime, the target being the center of downtown Atlanta as an explosion here would cause the greatest possible havoc. Then, medically speaking, we would be confronted with practically no local organized hospitals, at least 20,000 to

*Approved for publication by Mr. G. M. "Pup" Phillips, Director of Civil Defense, Atlanta Metropolitan Area.

**Chief of Medical Aid Section, Civil Defense Metropolitan Atlanta.

60,000 severely injured persons needing immediate hospital care for at least 24-48 hours, no electricity, no gas and no water.

To fit our needs, any plan must be general in its application, within economic limitation and as self-sufficient as possible. Elaborate plans are certain to break down in confusion.

In general, the most important phases of the entire Civil Defense Program applies even more keenly to medical aid; namely, dispersion of population, of facilities and of trained personnel. If people can be scattered prior to an attack, then there will be fewer casualties and more personnel with which to care for them. Plans to date have been formulated with this in mind.

Medical aid is but one of the 24 major services which are presently being organized on a local level. All services must be integrated in varying degrees. The center of Atlanta will be destroyed. Therefore, all services will have to be applied to the damaged area in radiating lines. The city has been divided into four divisions, each of which will be served by an information and administrative control center. These control centers will in turn be served by a master station, the purpose of the latter being to coordinate information from the four divisional centers in relation to the support area. Two of these centers have been completely activated and staffed. Medical personnel to direct the medical aid phase of these centers has been selected from among those who live and work 24 hours daily outside the probable target area.

If there is sufficient warning, general plans by CD authorities call for evacuation of school children up to and including the 7th grade, all pre-school children with mothers, patients in downtown hospitals and pregnant women past 5 months. Professional medical personnel, fire fighting equipment and key trained personnel are irreplaceable. In case of a yellow alert, CD plans call for evacuation of this personnel and equipment from the downtown area. If this action is not taken promptly and if the warning is not given surreptitiously, general panic may occur, resulting in impassable traffic jams. In Atlanta about 95 per cent of physicians are in their offices during working hours. This will be an area of severe damage and thousands of casualties.

The basic unit of civil defense is being organized on a city block basis. Ultimately, a warden will be put in charge of activities in each of Atlanta's 10,000 blocks. It is at this point that medical aid will first be applied. Trained professional personnel will not be available for this assignment and aid will be administered by lay trained First Aiders. During World War II, the British found First Aid Training for all adults to be their greatest morale builder. The need for physicians to recommend the course in Red Cross First Aid Training for laymen is obvious. Each block will have first aid equipment. Many persons with minor injuries can be cared for here and

returned to duty. Walking wounded will have to hitch-hike out of the area. Stretcher cases will be tagged, especially the unconscious, as identification here can be done more accurately than at any other point. Stretcher patients will be evacuated by ambulance.

There are approximately 1,000 laundry trucks in the Atlanta area. These trucks are to be used for ambulance service. Should an attack come during working hours, these trucks will be scattered over the city and thus survive. An assembly point will be set up in each of the four divisions to which medical personnel and ambulances will report and await assignment as soon as bomb damage can be ascertained.

The public school system has been chosen as the most logical basis for a system of temporary hospitals, First Aid and clearing stations. These buildings are scattered, offer a large area of floor space and lend themselves to organization on a neighborhood basis. In addition, all have facilities for feeding, all have a large auditorium for receiving a rush of casualties and many have only a ground floor. The public schools of Fulton, Cobb, DeKalb and Clayton Counties, including their respective city school systems, numbering roughly 140 schools, can be made to accommodate approximately 28,000 casualties. Only the most urgent procedures can be done here, otherwise all assigned professional personnel would be involved in the care of relatively few of the injured. We plan to use high schools for urgent procedures where facilities can be more elaborate and surgical teams can be made available. Here again only surgery which cannot await evacuation to better facilities will be done. The surviving organized hospitals will be used for definitive care but these can not hope to care for all casualties.

The evacuation of elementary schools will flow in many directions. The less severe stretcher casualties can be evacuated to nearby homes. Those casualties requiring immediate surgery will be evacuated to high schools. Those who can await definitive care will be evacuated to either local organized hospitals or to hospitals in distant cities. It is hoped that the latter can be accomplished primarily by air and secondarily by train. There are four large airfields in our immediate area.

In addition to the foregoing, the organization of provisional school hospitals is psychologically desirable as it will further impress the public with the fact that civil defense is an individual responsibility. Many details surround the organization of these schools. The casualty capacity of each school will be estimated on a floor-space basis of 3 by 7 feet, placing patients head to head in a center row in the class rooms. At present, all schools are taxed to their capacity with children, and storage space is not available. Pre-attack supplies will be stored in homes near these schools. Of these items, water is a most critical one and a

24 hour supply will have to be stored in one gallon jugs of which an abundant supply can be accumulated by local drug stores. Food storage will not present a particularly difficult problem. Stretchers can be largely home-made and stored in a similar manner. Flashlights and candles will be stored for lighting. Where schools depend on coal for heating, there will be no immediate problem but gas heating may be interrupted indefinitely. It is estimated that there is not enough surgical dressings on hand in the United States to care for the wounded from a single atomic bomb. Rolls of laundry-clean bandage can be prepared by the community in the form of 4 inch by 10 foot strips of sheeting, wrapped individually and placed in sealed cardboard cartons for storage in nearby homes. A survey of each neighborhood for usable supplies such as blankets, Coleman stoves, mattresses, etc. will have to be made. It will be necessary that a large map of the neighborhood be used in each school so that this storage information will be immediately available.

Medical personnel to staff these schools will be drawn from local physicians, dentists and nurses who survive or do not become casualties themselves. The deficit will have to be made up of persons secured from support areas. We do not anticipate a shortage of registered nurses as there is a reservoir of inactive registered nurses in each community. Corpsmen from World War II will also have to be located and utilized.

In time of need, state-law authorizes CD requisition of appropriate supplies from drug stores on the signature of authorized CD personnel. Thus narcotics and other current usable supplies will become readily available to physicians working in these schools. Assignment of drug stores on a neighborhood basis will be necessary. In event of an attack, a doctor will have to leave his office on short notice. If fortunate enough to survive, without preparation, he may arrive at a provisional school hospital empty handed. Therefore, we have

prepared a list of equipment which he should keep at his home at all times in case this need arises. A number of civilian defense police will be available to keep order in these schools. A system of communication between these installations and the control centers is of paramount importance.

Detailed organization of each school will be a community responsibility. The West End Civitan Club graciously consented to help organize a pilot provisional school hospital. Information obtained from this exercise will become the basis of a guide to all other schools in this area. We were profoundly impressed with the amount of widespread detailed and cooperative effort that this improvisation requires.

We can hardly make a good guess on the problem of blood transfusion. A solution will probably have to be arrived at on some standard national basis. One criticism of present blood-mobile collection of blood, as practiced by the Red Cross, is that all of this work is being done by a small group of highly trained persons. Wartime needs will require many trained technicians in widely scattered areas for this work.

Summary: The Atlanta organization for CD is being organized from top levels downward. We are trying to be prepared for a sudden increase in interest in the event the world situation worsens so that we can instruct volunteer workers in what is to be done. Our nation is confronted with an entirely new situation of huge proportions and persons engaged in CD have had to feel their way along so to speak. For this reason CD has not been pushed as rapidly as it might have been. This respite has allowed the much needed time required to formulate a program. We want to avoid being caught with volunteers on our hands with no sensible plan which can be put into immediate effect. On the other hand, without such a program it would be extremely difficult to engage the great number of persons required to make the program effective.

Civil Defense Briefs

Atlanta's first test of the use of a school as a temporary hospital in event of air raid was conducted at the Connally School in the West End section on the evening of September 28 under the sponsorship of the West End Civitan Club.

Beginning at 7 p. m., a team of "orderlies" cleared the school rooms. They were followed by crews of "housekeepers," who brought materials and supplies, and "clerks," who were prepared to keep records of admission, evacuation, death, injury classification and the like.

"Casualties" began arriving at 7:25 p. m. in the "receiving room" (the school auditorium). After their "injuries" had been "diagnosed" and the patients tagged, they were sent to different rooms for "treatment."

Medical care was under the direction of Dr.

Charles Eberhart, chief of medical aid for Atlanta's civil defense program. He was assisted by Dr. Bernard Wolff, Dr. Gene Hauck, Dr. Stedman Glisson, Dr. R. C. Hackney and Miss Lucy Mace, head of the nursing division.

Dr. Edgar M. Dunstan represented the Medical Association of Georgia at the Medical Civil Defense Conference held in Chicago on November 9-10. The conference, which had as its purpose the coordination and acceleration of civil defense medical planning, was sponsored jointly by the American Medical Association, the American Hospital Association, and the Association of State and Territorial Health Officers, in cooperation with the Federal Civil Defense Administration.

Organization

MEETING OF THE COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA

Academy of Medicine, Atlanta

September 23, 1951

Chairman W. G. Elliott, presiding.

Present were Drs. W. F. Reavis, President; C. F. Holton, President-Elect; David Henry Poer, Secretary-Treasurer; W. G. Elliott, Chairman of Council and Councilor of Third District; J. W. Chambers and Clarence B. Palmer, Fourth District; Marion C. Pruitt and John W. Turner, Fifth District; H. D. Allen, Sixth District; D. Lloyd Wood, Seventh District; Sage Harper and J. A. Leaphart, Eighth District; Bruce Schaefer and Charles R. Andrews, Jr., Ninth District; H. L. Cheves and J. Victor Roule, Tenth District; Spencer A. Kirkland, Chairman, Public Policy and Legislation Committee; Stephen T. Brown and C. C. Aven, Public Relations Committee; W. S. Dorough, Chairman, Insurance and Economics Committee; G. Lombard Kelly, Hugh Wood and C. H. Richardson, Medical Education and Hospitals Committee; Mr. John A. Dunaway, Attorney for the Association, Mr. Sid Wrightsman, Jr., Executive Secretary, and Miss Viola Berry, Assistant Secretary.

1. The minutes of Council meeting, May 20, 1951 and Executive Committee of Council meeting, June 24, 1951, were read and approved.

2. At the suggestion of President Reavis the chairmen of the special committees present submitted the following reports:

(a) Dr. Spencer A. Kirkland, Chairman, Public Policy and Legislation Committee read report of his committee which was approved (see minutes).

(b) Dr. W. S. Dorough, Chairman, Insurance and Economics Committee, discussed The Georgia Plan and reported that cost of booklets explaining the plan to the Association amounted to \$1,054.53, and \$933.03 has been paid by Commercial underwriters. The Provident Life and Accident Insurance Company has been chosen to underwrite the new Group Sickness and Accident Plan for the Association. The policy is non-cancellable and in order to accept this offer 50 per cent of our members must be enrolled by October 15.

(c) Dr. Stephen T. Brown, Chairman, Public Relations Committee, gave the PR report. He desired Mr. Wrightsman to make more visits over the State to District and County Society meetings. Dr. Aven reported on the PR Exhibit at the Fair-A-Ganza to be held in Atlanta, September 27-October 7.

(d) Dr. Marion C. Pruitt, Chairman, Medical Defense Committee, made a verbal report concerning the work of his committee.

(e) Dr. C. H. Richardson presented the report

for the Committee on Medical Education and Hospitals (see report).

3. The contract with Mr. Wrightsman, Executive Secretary and PR Director, with a salary of \$500 per month beginning September 15 was passed unanimously.

4. In the Office of the Association: (1) The new lighting fixtures installed at a cost of \$659 was approved. (2) A bookkeeping system is to be set up by direction of Ernst & Ernst, auditors of our Association, at a cost of approximately \$25 plus the cost of new books which will amount to approximately \$35 and this was approved.

The committee on Audits and Appropriations was requested to review the finances of the Association and make a report to the Executive Committee at its next meeting with recommendations regarding office expenditures. (4) It was voted that Mr. Wrightsman should be bonded for \$1,000 for three years at a cost to the Association of \$6.25.

5. It was voted to publish the new Constitution and By-Laws in the December issue of *The Journal*.

6. It was voted to give Mr. John A. Dunaway, Attorney for the Association, official power-of-attorney to relate solely to matters of the U. S. Treasury Department—Social Security and exemption of the Association from income tax as a non-profit organization.

7. Mr. Dunaway, as attorney for the Association, as legal counsel checked insurance policies for The Georgia Plan and submitted his bill for professional services which amounted to \$1,050. It was voted to pay the bill, but also to send a statement to the insurance companies for the cost of the legal counsel in connection with the checking of their individual policies. It was voted that in the future Mr. Dunaway is to check and recheck the insurance policies submitted and a fee of \$50 is to be paid by the individual insurance companies.

8. Mr. Wrightsman reported that Mr. Dunaway, our attorney, is working on the income tax status of the Association. As a non-profit organization we are exempt from paying income tax, but the Association has to prove this to the Government.

9. District Societies:

(a) Dr. Bruce Schaefer, Councilor of the Ninth District, reported that the membership problem in the Blue Ridge Medical Society has been settled to the satisfaction of all concerned.

(b) Dr. Lloyd Wood, Councilor of the Seventh District, reported progress made regarding the "marriage mill" situation in his district.

(c) Dr. H. D. Allen, Councilor of the Sixth District, made a motion that all complaints from his district be referred to the County Medical Society since it is a local problem.

(d) Dr. Sage Harper, Councilor of the Eighth District, was requested to investigate certain matters in his district. Since it is a local problem no action was taken.

(e) A report of controversy in the Fifth District regarding VA fee for dermatologists was presented. It was voted that Mr. Wrightsman write Admiral Boone requesting that the basic fee be raised to \$5.

(f) Dr. H. D. Allen, Councilor of the Sixth District, suggested the following names be sent to Governor Herman Talmadge to name one to fill the unexpired term of Dr. A. W. Bramblett, Forsyth, resigned, on the State Board of Health: Drs. C. L. Ridley, Sr., A. M. Phillips, C. H. Richardson, Jr., Leon D. Porch, all of Macon; Dr. C. B. Fulghum, Milledgeville, and Dr. E. B. Claxton, Dublin. The Secretary was instructed to write the Governor presenting these names for his consideration.

(g) Certain matters regarding the Fourth District were discussed but no action was taken.

10. It was announced that our delegates, Drs. B. H. Minchew, C. H. Richardson and Eustace Allen are planning to attend the AMA meeting in Los Angeles. Sid Wrightsman, Jr., Executive Secretary, was instructed to attend the PR Conference and General Sessions, if funds are available.

(a) Dr. Edgar Dunstan was requested to attend Civil Defense Conference to be held in Chicago, November 9-10, as representative of the Medical Association of Georgia with expenses to be paid by AMA.

(b) Representatives to attend the Conference of Editors of State Medical Journals to be held at AMA headquarters, Chicago, November 12-13, are Mr. Randolph L. Fort, Associate Editor, and Miss Viola Berry, Assistant to the Editor and Business Manager. The expenses are to be paid by the AMA.

11. Annual Session: Mr. Wrightsman reported 39 Technical Exhibit spaces had been sold at \$250 each, and a total of 78 spaces would be set up with additional space for Scientific Exhibits.

Report of Committee on Arrangements by Dr. Marion C. Pruitt, representing the Council, who stated that the plans are being worked out in a satisfactory manner.

No report from Dr. Richard Torpin, Chairman, Committee on Scientific Work.

12. The Journal of the Medical Association of Georgia:

Dr. Poer made a motion to invite Drs. V. P. Sydenstricker, Augusta; M. Hines Roberts, Atlanta, and Daniel C. Elkin, Emory University, to serve as the Editorial Board of *The Journal* and this motion carried. Also the Editorial Staff was approved: Mr. Randolph L. Fort, Associate Editor; Mr. Sid Wrightsman, Jr., Business Manager, and Viola Berry, Associate Editor and Assistant Business Manager. The subscription price of *The Journal* was to remain at \$5 per year, but \$3 per year for advertisers and professional represent-

atives.

It was voted to raise the advertising rates in *The Journal* 15 per cent beginning January 1952.

13. Dr. Poer announced the joint meeting of the Georgia Department of Public Health and the Medical Association of Georgia to be held at the auditorium of the Life Insurance Company of Georgia Building, corner of West Peachtree and Linden, October 11, at 10:00 A. M.

14. Next meeting of Council to be held in January, 1952—Sunday meeting.

15. Adjourned at 4:10 P. M.

MINUTES OF THE PUBLIC POLICY AND LEGISLATION
COMMITTEE OF THE MEDICAL ASSOCIATION
OF GEORGIA, SEPT. 23, 1951
Association Headquarters, Atlanta

Dr. Spencer Kirkland, Chairman, presiding. Present were Dr. W. F. Reavis, Dr. T. F. Sellers, Dr. Jack C. Norris, Dr. C. C. Aven, Dr. C. F. Holton, Mr. John A. Dunaway, Attorney for the Association, Mr. Sid Wrightsman, Jr., Executive Secretary, and Dr. Kirkland.

Senate Bill 1186 was discussed concerning drugs to be dispensed.

1. Local Bills discussed included: A practical Nurses Bill which had been approved by Georgia Nursing Association.

2. A bill to require a register of marriages and divorces will be introduced and a motion made for support by the Medical Association of Georgia was approved.

3. The premarital laws are being abused in Roopville. The Junior Chamber of Commerce sponsored the law with a three day waiting period which should alleviate abuse. Mr. Dunaway suggested Georgia Federation of Women's Clubs also sponsor the above law and three day waiting period.

4. Chiropractors, naturopaths and etc. should be restricted to their fields of practice. Bill should be sponsored by outside groups instead of by physicians.

5. Crippled Children's Program is now to be transferred to the Georgia Department of Public Health. Federal money \$300,000 to be matched by State \$100,000 could be used if transferred. Dr. Reavis made motion that the Public Policy and Legislation Committee approve the Legislature the transfer of money to the Georgia Department of Public Health Department which was approved.

6. Nurses Bill. The weakness of the bill was discussed. No school for such training. Certain areas will set up pilot schools for such teaching. The bill is also poorly drawn up. Dr. Reavis thinks much work needs to be done on the bill. A committee composed of Drs. Sellers, Aven, Kirkland, Holton to review and set up standards in law for practical nurses. Motion passed unanimously.

7. Dr. Sellers says the State has no proper teeth in LAWS to protect the professions from quacks. Tennessee has such a law. Dr. Aven says all peo-

ple in medical practice should have M.D. after names. Drs. Kirkland, Sellers and Poer with Mr. Dunaway to be investigative committee.

8. The Committee on Public Policy and Legislation has outlined its duties as follows:

1. To represent the Association in securing and enforcing legislation in the interest of public health and scientific medicine.

2. To keep in touch with professional and public opinion.

3. To endeavor to shape legislation so as to secure the best results for the entire population, and strive to organize professional influence so as to promote the general good of the community in local and national affairs.

4. To further the education of the general public in health matters.

5. To foster a sane point of view about proper medical care.

To carry out these duties the entire Committee is kept on the alert, not only during the session of the Legislature in Georgia, but throughout the entire year.

By being busy, we do not mean busy getting mixed in some controversy trying to get their names in the paper, photographs in the dailies or keeping in the limelights to promote one's own selfish motives. One can often write long letters and articles which result in a state of confusion and the good one has hoped to do is overshadowed by the damage which has to be corrected by someone. Very often the damage is beyond satisfactory correction.

The Committee has both local and federal bills to keep up with and handle. The Federal bills the Committee endeavors to maneuver over telephone, telegrams, air mail letters, night letters and direct or indirect contact. The local bills are handled very much the same way, only more direct contacts are established with the State Legislature than with the Legislature in Washington. The use of the phone is resorted to more in the State on account of the expense. The Committee oftentimes contacts a home town friend of a Legislatueman, or some friend in his surrounding section, with a request that he utilize his influence with his Senator or Representative, in the passage or non-passage of a medical bill. This friend may be a merchant, farmer, lawyer or physician. Very often a family physician has been of assistance to the committee.

The Woman's Auxiliary has given the Committee very much assistance, and they are always willing and ready to help. In fact, we call on any good citizen of the State from the Governor on down. The response for aid in the past has proven beneficial. Public Relations have helped us some.

A number of Federal bills have been brought up by Washington, which have a direct or indirect bearing on the medical profession. Possibly over two hundred pending at present. Lack of time will not permit taking up these bills and giving the

status of each. Very often these bills are amended, changed or substitute bills prepared before the original bill is forty hours old. So all the Committee can do with this type of bill is to keep up with such bill and render such assistance as indicated at the proper time. The War Clouds and Defense programs have overshadowed many of these bills. A number of stinkpot politicians, however, are busy trying to bring up bills that would gradually socialize medicine in the United States.

The local bills also give the Committee a headache at times; we have as much difficulty in preventing bills from passing that are detrimental to the medical profession, as we do in getting bills passed that are instrumental in the progress of medicine.

The Committee gets a great deal of criticism. It is so easy to sit back and say what one would do with certain bills if they were on the Committee. The Public Policy and Legislation Committee can only do the best they can and make every effort to retain a free country and utilize every force for the continuation of the practice of Free Medicine in the United States of America.

Adjourned at 10:45 A. M.

J. C. NORRIS, M.D.
Secretary

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

A meeting of this Committee was held in the Association headquarters on September 23. All members were present and Chairman G. Lombard Kelly presided. Drs. T. F. Sellers and R. C. Williams of the Georgia Department of Public Health met with the committee.

The Committee made the following recommendations:

1. That the Medical Association of Georgia support in every way possible the proposal to inaugurate a school of Hospital Administration—the course to be given by the Atlanta Division of the University of Georgia in cooperation with the Georgia Department of Public Health.

2. That the Medical Association of Georgia donate the sum of \$3,000.00 to the American Medical Association Educational Fund.

3. That (a) nursing education in the State General Hospital in affiliation with Medical College of Georgia be conducted jointly by faculty of the Medical College of Georgia and the administration of the hospital in cooperation with the nursing education department of the University of Georgia. (b) It is further recommended that in this program of nursing education great emphasis be placed on the training of bedside nurses, as well as the training of nurses for service as nursing education and supervision.

4. It is the opinion of this committee that the present plan of postgraduate education as conducted by the two medical schools of the state is

the best solution of this problem at the present time.

5. It is the sense of this Committee that we endorse the action of the Committee on Public Policy and Legislation looking to a plan of study which would strengthen the Medical Practice Act as related to forms of medical care.

R. HUGH WOOD, M.D.

C. H. RICHARDSON, M.D.

G. LOMBARD KELLY, M.D., Chairman

REPORT OF MEETING OF COMMITTEE ON SCIENTIFIC WORK

A second meeting of the Committee was held in the headquarters of the Association, Atlanta on October 11, with Dr. Richard Torpin, Chairman, presiding. The acting chairmen of the following Sections met with the Committee to discuss plans for the program of the 1952 Annual Session of the Medical Association of Georgia:

General Practice—Dr. W. W. Daniel, Atlanta

Internal Medicine—Dr. Carter Smith, Atlanta

Public Health—Dr. T. F. Sellers, Atlanta

Surgery—Dr. Luther Wolff, Columbus

Urology—Dr. Reese Coleman, Jr., Atlanta

Pediatrics—Dr. John A. Simpson, Athens

Obstetrics and Gynecology—Dr. Richard Torpin, Augusta

Eye, Ear, Nose and Throat—Dr. Fred N. Aldrich, Macon

Orthopedics—Dr. Peter B. Wright, Augusta

Radiology—Dr. Wm. W. Bryan, Atlanta

Pathology—Dr. Everett L. Bishop, Atlanta

Scientific Exhibits—Dr. R. Hugh Wood, Atlanta

Also Dr. James H. Semans, Atlanta, Chairman of the Committee on Arrangements for the Fulton County Medical Society, met with the Committee.

Following the same plan as outlined in the August number of *The Journal*, each section was requested to formulate plans for a separate meeting during Monday and Tuesday afternoons of the Annual Session. Also each Section was requested to invite a guest speaker who would participate in the general programs during the morning, as well as the Section programs in the afternoon. Methods of paying the expenses of the guest speakers was discussed and each Section was requested to look into ways and means of obtaining the necessary funds.

All medical schools in the Southeast will be invited to present Scientific Exhibits.

(Up to the time of going to press the following groups have offered to assist in providing guest speakers:

General Practice:

1. Georgia Heart Association

2. Private donation

Pediatrics: Private donation

Medicine:

1. Association of Chest Physicians

2. Georgia Heart Association

Surgery:

1. Georgia Chapter, American College of Surgeons

2. Georgia Division, American Cancer Society
Public Health: Georgia Department of Public Health
Radiology: Georgia Radiology Society
Urology: Georgia Urological Association

In addition, the Calhoun Lectureship will provide one speaker and the Association will pay the expenses of two others. Thus a total of 12 or 13 outstanding guest speakers are assured for the Annual Session. Editor).

MEETING OF EXECUTIVE COMMITTEE OF COUNCIL Hotel Dempsey, Macon, October 26, 1951

Present were Drs. W. F. Reavis, President; David Henry Poer, Secretary-Treasurer, and D. Lloyd Wood, member of Council.

1. Report of Committee on Audit and Appropriations: Drs. J. W. Chambers, Chairman, H. L. Cheves and Bruce Schaefer, was read. After all figures were taken into consideration the above named committee recommended that no additional expenditures be considered except those which are absolutely necessary to the efficient operation of our Association prior to March 31, 1952.

2. The requests for special funds by two members of the Woman's Auxiliary were referred back to that organization for action.

3. Correspondence concerning the practice and activities of naturopaths, chiropractors and other quacks was discussed and it was voted that the Secretary advise officials of the local societies concerning proper action. Also the Public Policy and Legislation Committee of the Association was requested to continue its Practice Control Act to protect the citizens of this State.

4. The Public Policy and Legislation Committee was requested to present a new Practice Control Act for Georgia to protect the people of Georgia by establishing proper legislation. It was recommended that a member from each Councilor District be appointed to work with the above named committee composed of Dr. Spencer A. Kirkland, Chairman, Dr. Jack C. Norris, Dr. C. C. Aven, Dr. W. F. Reavis, and Dr. C. F. Holton, who were appointed in May. The new committee will be made up of the following: First District, Dr. Ralph O. Bowden, Savannah; Second District, Dr. J. A. Redfearn, Albany; Third District, Dr. Robert C. Pendergrass, Americus; Fourth District, Dr. Hollis Hand, LaGrange; Fifth District, Dr. Allen H. Bunce, Atlanta; Sixth District, Dr. Tyrus C. Cobb, Jr., Dublin; Seventh District, Dr. William P. Harbin, Jr., Rome; Eighth District, Dr. James L. Campbell, Jr., Valdosta; Ninth District, Dr. Grady Coker, Canton; Tenth District, Dr. J. Victor Roule, Augusta.

5. Mr. Sid Wrightsman, Jr., Executive Secretary and PR Director, was directed to attend the Clinical Session of the AMA and PR Conference to be held in Los Angeles December 2-7, with expenses paid from PR funds.

6. Social Security matters for employees are to be handled by Dr. Poer, Secretary-Treasurer, as he sees fit.

7. Dr. Edgar M. Dunstan, Atlanta, was requested

to represent the Medical Association of Georgia at the Civil Defense meeting of AMA in Chicago, his expenses to be paid by that organization.

8. Mr. Randolph L. Fort and Miss Viola Berry, associate editors of *The Journal* were directed to attend the State Medical Journal Conference at

AMA headquarters, Chicago, November 12-13, with expenses to be paid by AMA.

9. Dr. Reavis appointed Dr. C. N. Wasden, Macon, to continue as chairman of the Industrial Health Committee until the next Annual Session of our Association.

FROM THE GEORGIA PRESS

A Hospital Isn't Run for Profit

The full report of the Grand Jury committee on operation of the Griffin-Spalding Hospital and Hospital Administrator Eric Barton's explanation of profits shown the last two months as reported in this newspaper should go far toward familiarizing the public with their hospital's problems and functions.

For months the hospital operated in the red. Then came an economy drive, an unusually heavy number of patients, an unusually light consumption of drugs and a severe shortage of personnel which naturally reduced salary expenses.

It is fine to see the hospital operate in the black and show a profit, but, as Administrator Barton cautioned, continued profits cannot be expected. The profitable months are needed badly to offset the months when there are heavy losses.

There are bound to be losses some months because an adequate staff must be maintained to care for heavy patient loads as well as light.

We were glad to learn that the hospital does not expect to make a profit, for making a profit is not the function of a city-county hospital such as ours. Its true functions and purposes are to care for the sick at as reasonable a cost as possible.

The hospital will do well to break even and we hope that it can. But the important thing is proper care for the sick. Only by the manner in which a hospital cares for its patients can its success be measured. Financial success is purely secondary.

We are assured that if the time comes when the hospital operates continuously in the black, the profits will be passed on to patients in reduced rates. We hope this day will come, but don't expect it any time soon.—Quimby Melton, Jr. in the *Griffin Daily News*.

Selling Socialism

In a recent Saturday Evening Post article, which has been widely quoted and reprinted, Charles Stevenson described government activities in the field of propaganda—paid for, of course, by all the taxpayers.

One section of his article dealt with the Federal Security Agency's labors on behalf of compulsory government health insurance and related legislation. According to Mr. Stevenson, anyone who challenges the program "stands denounced in the FSA's speech-news release as a "reactionary" who

"is against health, against social security, against education, against a living wage, against everything that means anything to ordinary people, and in the end against our very liberty, our opportunity, our hopes for the future."

Mr. Stevenson also pointed out that the American Medical Association was roundly abused for spending money to fight compulsory health insurance, which it believes would dangerously undermine our standards of medical care and make the doctor the servant of the politician. Yet, he said, FSA has apparently been spending far greater tax-supplied sums for its own propaganda. He cited a case where a man appeared before a congressional committee to argue for health insurance as an independent citizen. He got in 9,000 words of testimony before questioning disclosed he was a full-time government employee. He was then in the Labor Department, and later was employed by FSA.

Mr. Stevenson described many such instances. Every possible form of pressure was used to sell a health insurance scheme which, if historical precedent means anything, would have been merely a prelude to socialized medicine. Mr. Stevenson said, "These campaigns are typical of propaganda techniques that are spreading throughout the government."

Luckily, the people weren't fooled—the health insurance scheme has been shelved. But that's only a temporary stratagem. It will be back—and the only way we can be sure of stopping is to be eternally vigilant.—*The Madisonian*, Madison.

Editors Fight Socialized Medicine

It is to the credit of the newspaper fraternity that the great bulk of our papers, and most especially the smaller papers, have been leaders in the fight against socialized medicine and government-controlled or influenced medicine. This was done as a matter of principle—not because of any particular personal worry as to the welfare of doctors. The typical editor knows full well that socialized medicine would be a long step toward the totally socialized state. And he knows that it would inevitably result in a sharp decline in preventive medicine. The experience of England has proven this.—*Sandersville Progress*.

General Interest

CALENDAR OF MEETINGS

AMERICAN MEDICAL ASSOCIATION, Clinical Session, Biltmore Hotel, Los Angeles, Calif., December 3-7.

SOUTHERN SECTION OF AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, INC., Academy of Medicine, Atlanta, January 14. Dr. Lester A. Brown, Atlanta, Vice-President.

DISTRICT AND COUNTY SOCIETIES

DECEMBER 5—Sixth District Medical Society meets Macon, 2 p. m. Dr. Charles H. Richardson, Jr., Macon, Secretary.

DECEMBER FIRST WEEK—First District Medical Society meets Statesboro. Dr. William H. Fulmer, Savannah, Secretary.

DECEMBER FIRST WEEK—Fourth District Medical Society meets Newnan. Dr. James N. Bryant, Jr., Newnan, Secretary.

THE SECOND DISTRICT MEDICAL SOCIETY held its semi-annual meeting at the Elks Club in Thomasville, and decided that its next meeting would take place in Tifton the first Thursday in April, 1952. Papers were read at the Thomasville meeting by Dr. David Henry Poer, Atlanta; Dr. Paul W. Lucas, Tifton; Dr. Fred E. Murphy, Thomasville; and Dr. David S. Mann, Albany. Presiding at the meeting was Dr. C. K. Sharp, Arlington, president of the Society.

THE FIFTH DISTRICT MEDICAL SOCIETY met at the Academy of Medicine, Atlanta, on November 15 and heard addresses by two members of the faculty of Bowman-Gray School of Medicine: Dr. Wingate M. Johnson, professor of medicine, and Dr. H. H. Bradshaw, professor of surgery. Dinner was served in the Academy dining room, with Mrs. Murdock Equen, president of the Fifth District Auxiliary, in charge.

THE SEVENTH DISTRICT MEDICAL SOCIETY met on September 26 at the American Legion Club in Cedartown, as guests of the Polk County Medical Society. Scientific papers were given by: Dr. Lee H. Battle, Jr., Rome; Dr. Edward Bosworth, Rome; Dr. W. D. Hall, Calhoun; and Dr. Dixon Fowler, Atlanta. Rev. Roger W. Stone gave the invocation and Dr. P. O. Chaudron the address of welcome at the meeting. Presiding was Dr. Ralph Fowler, Marietta, president of the district society. Dr. W. C. Mitchell was appointed to represent the district

on the association's subcommittee on public health. The group voted to hold its next meeting in Dalton next April.

THE EIGHTH DISTRICT MEDICAL SOCIETY met at St. Simons on October 6 and scheduled its next meeting for Douglas in April. The Society elected as officers Dr. L. W. Pierce, Waycross, president; Dr. J. B. Brown, Baxley, vice-president; and Dr. Sage Harper, Douglas, secretary-treasurer.

THE DEKALB COUNTY MEDICAL SOCIETY met on October 8 at Emory University Hospital, immediately after 14 of its members had offered to give blood at the Red Cross Blood Center there and 11 had made donations. In pressing their campaign for the giving of blood, the DeKalb physicians decided to set an example. All eligible members of the Society plan to make donations as and when they are able. Presiding at the meeting, which followed a dinner at which the hospital was host, was Dr. Richard H. Smoot, president of the society.

THE DOUGHERTY COUNTY MEDICAL SOCIETY held its monthly meeting at the Phoebe Putney Memorial Hospital, Albany, on October 25. Guest speaker was Dr. David Wolfe, who gave an address on "The Physician and Public Health."

THE FULTON COUNTY MEDICAL SOCIETY met on October 18 at the Academy of Medicine, Atlanta. After dinner was served, Dr. Paul B. Beeson served as moderator of the scientific program. Papers were read by Dr. Max Michael, Jr., and Dr. John McClure.

THE WARE COUNTY MEDICAL SOCIETY met on October 4 at the Atlantic Coast Line Hospital in Waycross, with Dr. Sam Andrew and Dr. W. O. Inman, Jr. as co-hosts. Dr. H. T. Adkins, vice-president, presided in the absence of Dr. W. C. Calhoun, president. Dr. Samuel Victor was welcomed as a new member. Feature of the meeting was the showing by Dr. T. J. Ferrell of a motion picture of an operation he had performed on a patient in Ware County Hospital; this was the first time a motion picture film of an operation had been made in Waycross.

ANNOUNCEMENTS

The GEORGIA COMMISSION ON ALCOHOLISM announces that a Symposium on Alcoholism will be held in the Atlanta Municipal Auditorium on January 18. Four out-of-state speakers will appear on the symposium program: Dr. Raymond G. Mc-

Carthy, executive director, Yale (University) Plan Clinic; Dr. Leon A. Greenberg, assistant director, Laboratory of Applied Physiology, Yale; Ralph M. Henderson, Section of Alcohol Studies, Yale; and Dr. E. C. Hoff, medical director, Virginia Program on Alcoholism.

THE MEDICAL COLLEGE OF GEORGIA announces the following two postgraduate courses to be conducted there next spring: (1) Dr. Charles W. Hock, assistant professor of medicine, has scheduled a course entitled "Advance in Medicine" for March 3-5. (2) Dr. Robert B. Greenblatt, professor of endocrinology, announces that the Eighth Postgraduate Course in Endocrinology for May 26-31; this class will be limited to 60, and its fee will be \$60.

THE AMERICAN UROLOGICAL ASSOCIATION offers an annual award of \$1,000 (first prize of \$500, second of \$300, third of \$200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists. For full particulars, write the secretary of the Association, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey. Essays must be in his hands before Feb. 15, 1952. The first-prize essay will appear on the program of the meeting of the Association in Atlantic City June 23-26.

The JONTE EQUEN MEMORIAL LECTURE will be delivered on November 29 by Dr. Louis H. Clerf, noted Professor of Laryngology and Bronchoesophagology, Jefferson Medical College, Philadelphia, on "Carcinoma of the Air Passages", a subject of vital interest to both lay and medical men. This lectureship was established by Dr. Murdock Equen in memory of his father, the late Jonte Equen, a New Orleans grain broker.

Dr. Clerf is a graduate of Jefferson Medical College, Philadelphia. He is a Captain in the U. S. Naval Reserve and he has been awarded the honorary degree of Doctor of Law. He is a past president of the American Laryngological, Rhinological and Otological Society, American Broncho-Esophagological Association, and the Philadelphia County Medical Society; a member of the American Board of Otolaryngology, American Academy of Ophthalmology and Otolaryngology, American College of Surgeons, American Association of Thoracic Surgery, American College of Chest Physicians and American Gastro-Enterological Association. He is a past chairman of the Section of Otology, Rhinology and Laryngology of the American Medical Association and is now the Secretary of the American Laryngological Association. His scores of papers have greatly contributed to the progress of medical science.

Dr. Clerf will discuss the various procedures which can be carried out to diagnose carcinoma of

the air passages, with particular reference to the larynx and tracheobronchial tree, as well as possible predisposing etiologic factors and symptoms. He will also discuss plans of therapy and methods of rehabilitation of such surgically treated patients. Lantern slides will accompany his presentation of this new timely subject.

The lecture will be held at the Academy of Medicine, Atlanta, at eight o'clock and is open to the public. Refreshments will follow the lecture.

PROFESSIONAL GROUPS

Dr. Luther H. Wolff, Columbus, was elected to succeed Dr. Peter B. Wright, Augusta, as president of the GEORGIA CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS at the organization's meeting in Augusta on October 18. Dr. Wright became councilor of the chapter.

Other officers elected were: Drs. Thomas Harold, Macon; vice-president; J. H. Semans, Atlanta, secretary; Joseph C. Read, Atlanta, treasurer; Daniel C. Elkin, Atlanta, regent; and Walter Holmes and David Henry Poer, both of Atlanta, governors.

The chapter voted to meet next year in Columbus. Sixth chapter of its kind to be organized among the 30 now in existence in the country, the group received its charter at the Augusta meeting. About 250 persons attended the sessions.

Awards for papers were made by the chapter as follows: To Drs. E. D. Grady and P. F. Brown, of Lawson Hospital, Atlanta, \$100 for a joint paper on the treatment of cancer by intermittent injections of nitrogen mustard into the arteries; to Dr. John R. McClure, Atlanta, \$75 for a paper on massive gastrointestinal hemorrhage treatment with powered gelfoam and thrombin.

Registered nurses from all parts of Georgia assembled in annual convention on November 4-7 at the Ansley Hotel, Atlanta. The GEORGIA STATE NURSES ASSOCIATION, with a membership of more than 2,700, held its 45th annual session and its five sections held business and program meetings. The GEORGIA STATE ORGANIZATION FOR PUBLIC HEALTH NURSING held its 26th session, the GEORGIA LEAGUE OF NURSING EDUCATION held its 25th annual meeting, and the GEORGIA ASSOCIATION OF INDUSTRIAL NURSES its eighth session.

The FOURTH OCCUPATIONAL VISION CONGRESS was held in the Hightower Textile Building at the Georgia Institute of Technology, Atlanta, on October 4-5. Its purpose was to seek ways of utilizing manpower to the fullest extent during periods devoted to national defense.

Sponsoring the congress were: the Georgia Optometric Association, Georgia Society of Ophthalmology, Industrial Hygiene Division of the Georgia Department of Public Health, Associated Industries of Georgia, Cotton Manufacturers As-

sociation of Georgia, Georgia Association of Industrial Nurses and Illuminating Engineering Society, in cooperation with Georgia Tech and the Institute of Public Safety.

National guests of the four nursing groups included: Mrs. Dorothy R. Hinckley and Miss Margaret T. Cleary, assistant executive secretaries of the American Nurses' Association; Dr. Elizabeth Kemble, dean, School of Nursing, University of North Carolina, and chairman of the technical committee of the American Nurses Association's Study of Nursing Functions; Miss Thelma Durham, of Memphis, Tenn., president of the American Association of Industrial Nurses; and Miss Margaret Hargreaves, of New York, chairman of Standing Orders in Industry, A.A.I.N.

Among those who welcomed the nurses of the state was Governor Herman E. Talmadge. Members of the Fifth District G.S.N.A. held open house for their guests on Sunday, November 4.

Tribute was paid at the convention to nurses who had died since last year's convention by a short memorial service and the traditional basket of red and white flowers in G.S.N.A. colors. Theme of the meeting was "Service Through Nursing."

Social highlights included: open house on Sunday; a luncheon and a tea on Monday, a luncheon, a banquet and dance on Tuesday; and special breakfasts for Office Nurses and Private Duty Sections on Monday and Tuesday. Members of G.A.I.N. were entertained at dinner on Monday by the Industrial Nurses' Club of Atlanta, who also gave the tea on Monday. The Georgia State League of Nursing Education sponsored a luncheon on Wednesday, at which student nurses were given an interesting program. Speaker at the banquet on Tuesday was Lieutenant Governor Marvin E. Griffin, whose subject was "Americanism."

The following "Resolution Opposing Medical Cultists in the Veterans Administration" was adopted on October 6 by the ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS at its annual meeting in Indianapolis, Ind.:

"Whereas, it has come to the attention of the Association of American Physicians and Surgeons that various groups of irregular healers are attempting to use the great veterans' organizations to further their questionable purposes and force acceptance of their healing practices in the Veterans Administration, and

"Whereas, the members of this Association, as regular physicians with the degree of Doctor of Medicine, have worked diligently to improve the quality of medical service rendered the veterans qualified to receive it from the Veterans Administration and have succeeded, as physicians, in raising the quality of this care to an all-time high universally accepted as the best in the world, and

"Whereas, this Association feels that veterans' organizations should help medical authorities to

maintain the high standards now employed in medical care in the V. A. and not assist the cultists in their efforts to lower these standards.

"Therefore, be it resolved that this Association in convention assembled does hereby petition the large veterans' organizations of this country to do nothing that will further the efforts of medical cultists, such as chiropractors, to infiltrate into the medical program in successful operation at this time in the Veterans Administration and further to do all in their power to aid the regular medical profession in maintaining these high standards against all onslaughts.

"Be it further resolved that this Resolution be dispatched at once to the national officials of the principal veterans' organizations for their information and action, especially the American Legion which will shortly hold its annual convention."

The annual meeting of the GEORGIA ACADEMY OF GENERAL PRACTICE was held at the Idle Hour Country Club, Macon, on October 25, with Dr. Walter W. Daniel, of Atlanta, president, presiding. At the morning business meeting, the following officers for 1951-52 were elected: Dr. Albert R. Bush, Hawkinsville, president; Dr. Peter Hydrick, College Park, vice-president, and Dr. Maurice Arnold, Hawkinsville, secretary-treasurer.

A resolution was introduced by Dr. Thomas G. Peacock, Milledgeville, petitioning the American Academy of General Practice to investigate the State Mental Hospital at Milledgeville with the view of approving it for training of interns of general practice. The resolution was unanimously adopted.

Following a noon social hour and luncheon, members were addressed by Leo Brown of Chicago, public relations director of the American Medical Association, on "Doctor-Patient Relationship."

The following scientific program proceeded during the afternoon: "Management of Eclampsia and Preeclampsia," Dr. Robert Kennon Hancock, Atlanta; "Practical Application of the Barium Enema," Dr. Robert C. Pendergrass, Americus; "The Acute Abdomen," Dr. Phillip Thorek, Chicago; "Evaluation of Clinical Importance of ACTH and Cortisone," Dr. Paul B. Beeson, Atlanta, and "Scurvy," Dr. Philip A. Mulherin, Augusta.

PERSONALS

Transition

DR. E. WAYNE CULBRETH, who in June completed a year's internship at the Naval Hospital, Portsmouth, Va., is now associated with Dr. James B. Martin in the practice of medicine and surgery in Edison.

DR. GEORGE D. MEADOR, a graduate of the University of Texas School of Medicine, has located in Cairo and announced his association

with Dr. A. W. DeLoach, who recently located there for the practice of general medicine and surgery.

DRS. L. H. MUSE and JULIAN Q. WATTERS announce the removal of their offices to 1102 West Peachtree St., N. W., Atlanta.

DR. J. DEAN PASCHAL has opened office at 717 North Monroe St., Albany. Diseases of infants and children.

DRS. C. S. PITTMAN and CARL PITTMAN, JR. have begun construction of a new office building at 10th Street and Tift Avenue, Tifton.

DR. JOHN PAUL PUCKETT, formerly of Gadsden, Ala., has located in Blue Ridge.

Helpmeets

DR. JOHN W. DANIEL, JR. and Mrs. Elizabeth Lynah Rumsey, both of Savannah—married October 16 in Atlanta.

DR. WILLIAM B. DILLARD, of Cartersville, and Miss Jane Culver Jernigan, of Birmingham—engaged to be married in December.

DR. GEORGE R. MAYFIELD and Miss Janie Elizabeth Hillman, both of Augusta—married on November 3.

DR. ANNE WILKINSON WAGAR and Maurice James Moore, III, both of Atlanta—engaged to be married.

For Your Admiration

TO DR. AND MRS. G. L. FORBES, JR., Atlanta, a son, Robert Walter, June 3.

TO LT. JOSEPH P. HENDRIX, Army Medical Corps, and Mrs. Hendrix, Valdosta, a son, William Newton, September 14. Dr. Hendrix is on duty in Korea.

TO DR. AND MRS. WILLIAM P. LEONARD, Atlanta, a daughter, Molly Cary, September 14.

TO DR. AND MRS. JASON L. MEADORS, Atlanta and Camp Stewart, a daughter, Penelope, September 15, in Savannah.

TO LT. SAMUEL O. POOLE, Army Medical Corps, and Mrs. Poole, Augusta, a son, Samuel O., Jr., September 16. Dr. Poole is on duty at the Station Hospital, Camp Gordon.

TO DR. AND MRS. NORMAN F. STAMBAUGH, Atlanta, a daughter, Diane, Augusta 24.

TO DR. AND MRS. J. E. TAYLOR, JR., Decatur, a son, Stephen Douglas, July 9.

DEATHS

BEAZLEY: *Dr. Alexander Hamilton Beazley*, 71, of Crawfordville, died on September 5. Born and reared in Crawfordville, he spent his entire

life there. Was graduated from Atlanta College of Physicians and Surgeons, 1905. Thirty minutes before he was stricken, Dr. Beazley treated his last patient. There being no other doctor in the town, he diagnosed his ailment and prescribed his own treatment of his final illness.

BRADLEY: *Dr. T. E. Bradley*, 71, of Fitzgerald, died September 29 after being found in a semi-conscious condition in his room in the Lee-Grant Hotel. For several years he had suffered a heart ailment which necessitated his taking rest periods from his practice. Moving to Fitzgerald in 1934 to specialize in eye, ear, nose and throat, Dr. Bradley previously had practiced in Nashville, Osierfield and Cordele.

GARNER: *Mrs. Birdie Patterson Garner*, 70, wife of Atlanta physician Dr. J. R. Garner, was killed October 18 in the driveway of her home by her own runaway automobile. The brakes of the parked car failed to hold, and it rolled backward over Mrs. Garner as she was preparing to remove groceries from the trunk.

HUDSON: *Dr. Joseph Haskell Hudson*, 60, of Gough (Burke County), died September 28 at University Hospital, Augusta, where he had been confined five weeks. Graduate of the Medical College of Georgia, 1912, he had lived in Gough 35 years.

WARING: *Dr. Antonio Johnston Waring, Sr.*, 70, Savannah pediatrician, died October 8 after a week's illness. Graduated by Yale University and Columbia University College of Physicians (1908), he went to Savannah to open a general practice. Later he became one of the first Savannah physicians to specialize in pediatrics. At time of death, Dr. Waring was chairman of Savannah Park and Tree Commission. Was past president of Savannah Rotary Club and charter member of Cosmos Club.

WISE: *Dr. Bowman J. Wise*, 63, retired Plains physician, died October 17 in Americus, five days after suffering a heart attack. Graduate of Tulane University School of Medicine, he formerly operated the Wise Sanitarium at Plains and later the Wise Clinic in Americus with his brothers, the late Dr. Sam Wise and Dr. Thad Wise. Retired from practice about six years ago.

MILITARY

After a long delay, the new regulations under the Universal Military Training and Service Act have been published in full. Several of them are applicable to "special registrants," namely, the majority of the country's practicing physicians, dentists and veterinarians.

Those in Priorities I and III are to report for induction by age, the youngest being selected first. Call-ups of Priorities II and IV are by length of

prior service in the military forces, those with the least service being inducted first. For the first time, regulations include pharmacy, chiropractic and chiropody among healing arts whose students are deferrable.

Figures at Selective Service headquarters, as of August 31, reveal the induction as privates of four physicians, one dentist and no veterinarians.

MISCELLANY

DR. WALLACE L. BAZEMORE, Macon urologist, recently began restoring his grandfather's antebellum estate and plantation, on which he intends to raise cattle.

DR. TROY BIVINGS, Atlanta, was one of several Georgians recently receiving from the Atlanta Alumni Association of the Sigma Alpha Epsilon fraternity a certificate for having been a member of the fraternity for 50 years or more.

DR. MIRIAM CHAMBLISS, Harris County's only woman physician, was honored on September 30 by women from throughout the county at a miscellaneous shower at the American Legion home in Pine Mountain Valley. She and her husband, Dr. William Chambliss, recently purchased a house in Pine Mountain Valley and plan to make their home there. They operate the clinic at Hamilton.

DR. HAL DAVISON, Atlanta, in September flew to Zurich, Switzerland, where he appeared on the program of the International Association of Allergists.

DR. ROBERT H. GILLESPIE, Atlanta, has been made a diplomate of the American Board of Obstetrics and Gynecology.

DR. J. HIRAM KITE, surgeon-in-chief of the Scottish Rite Hospital for Crippled Children, Decatur, and assistant professor of clinical surgery (orthopedics) in the Emory University School of Medicine, on October 3 addressed the 22nd annual Scientific Assembly of the Medical Society of the District of Columbia on "Early Diagnosis and Management of Some Problems in Pediatric Orthopedics."

DR. J. E. LESTER, Marietta, recently was honored at a luncheon given by staff members of the Cobb County Health Department in celebration of his 75th birthday anniversary and in honor of his 25 years of service as health commissioner of Cobb County.

DR. AND MRS. J. F. MIXSON, SR., Valdosta, recently celebrated their golden wedding anniversary.

DR. R. C. MONTGOMERY, Butler, has announced that he will take a period of rest and until further notice will not engage in medical practice. His son, Dr. Clifford Montgomery, is taking his calls.

DR. A. JOHN MOONEY, Statesboro, has been elected president of the Statesboro Rotary Club.

DR. NEWDIGATE M. OWNESBY, Atlanta, has been appointed by the board of trustees of the American Academy of Neurology to membership on the newly formed committee on public legislation of the academy.

DR. A. M. PHILLIPS, Macon, has been sworn in as a member of the State Board of Health, succeeding Dr. A. W. Bramblett, Jr., Forsyth, resigned.

DR. W. J. RHODES, retired Louisville physician, is the oldest living graduate of the Medical College of Georgia, from which he received his M.D. degree on Mar. 4, 1884. He practiced in Bartow for about 12 years and in Louisville thereafter, his years of active practice numbering 48. Dr. Rhodes retired 18 years ago; now, at 93 (he will be 94 in December), he is confined to his bed but his mind is very clear.

DR. PERRY P. VOLPITTO, professor of anesthesiology at the Medical College of Georgia, addressed the American Society of Anesthesiologists on November 8 at its annual meeting in Washington, D. C. Dr. Volpitto is second vice-president of the society.

DR. L. C. WATKINS, medical director of the U. S. Public Health Service Hospital, Savannah, has been appointed to serve with Dr. C. A. Henderson, city-county health officer, as assistant deputy director of the Chatham-Savannah Defense Council. Dr. Henderson, a deputy director of the council, also will be assisted by Dr. T. A. Peterson.

DR. VIRGENE SHEARER WAMMOCK, chief of the dermatology section at the Camp Gordon hospital, addressed members of Alpha Epsilon Iota, women's medical fraternity, in Augusta on October 9. Dr. Wammock, wife of Dr. Hoke Wammock, of the Medical College of Georgia faculty, discussed the uses of the newer antibiotics in the treatment of venereal diseases.

The "Get a Doctor for Oconee" movement, a campaign which has been under way for at least two years, last month bore fruit.

Long without the services of a physician, Oconee County and Watkinsville, the county seat, have been making diligent efforts to obtain them. Late in September Dr. Harry Talmadge and his associate, Dr. Ronald Gustin, both of Athens, met with a group of about 150 Oconee citizens and discussed a plan whereby such help might be had.

As a result of the conference, Dr. Gustin in October began keeping afternoon office hours each day in Watkinsville, with Dr. Talmadge joining him in the office on Thursday afternoons. One or

the other is available for night calls. They are situated temporarily in a building next to the post office while the citizens of the county go about securing more adequate office space and facilities.

Lending their hearty support to a drive for a large turnout when the Red Cross Blood Bank took donations in Forsyth on October 11, the physicians of the city all wrote letters which were published on the front page of the *Monroe Advertiser the week before*. Penning their personal appeals were Drs. John P. Heard, George H. Alexander, Thomas Hodges and A. W. Bramblett, Jr. Dr. Heard, a major in the Army Medical Corps, wrote with particular authority, for he had only recently returned from Korea, where he had administered blood and plasma to wounded soldiers.

Citizens of Adel and Cook County now have immediately available modern x-ray equipment. John P. Bridges, registered x-ray technician, has opened a fully equipped office in the Sowega Building.

The price of medical care, including drugs, hospital room rates and physician and dental services, was relatively 14 per cent cheaper in 1950 than during 1935-39.

This was revealed recently in the Consumers' Price Index, compiled by the U. S. Bureau of Labor Statistics.

The Bureau's Index indicated a 72 per cent rise in the cost of living since the 1935-39 base period while, at the same time, showing that medical care prices rose only 48 per cent.

The increase for food, the Index showed, was 104 per cent; apparel 88 per cent; rent 31 per cent; fuel, electricity and refrigeration 41 per cent; house furnishings 90 per cent, and 57 per cent for the items which the Bureau of Labor Statistics classified as miscellaneous. Only two of these items—rents, and fuel, electricity and refrigeration—rose less rapidly than medical care prices.

The 72 per cent rise in the cost of living as compared with only a 48 per cent rise in medical care prices indicates that for every \$1 paid for goods and services generally in 1935-39, the 1950 consumer had to pay \$1.72. On the other hand, the medical care purchased for \$1 in 1935-39 cost only \$1.48 in 1950.

An analysis of the Index discloses further that a dollar in 1950 could buy 68 cents worth of medical care but only 58 cents worth of all goods and services, or 86 per cent as much. The 1950 purchasing power of the dollar was 86 per cent as high in terms of goods and services, generally, as it was in terms of medical care prices only. Thus, in terms of the purchasing power of the 1950 dollar, medical care was relatively 14 per cent cheaper than in 1935-39.

Physicians' fees, according to the Index, rose 40 per cent or only a little more than half as

rapidly as the entire cost of living, which rose 72 per cent.

Only hospital room rates, which increased 135 per cent, have risen faster than the entire Consumers' Price Index.

"The high hospital rates," on A.M.A. study of the Consumers' Price Index, said, "reflects the fact that hospitals are singularly exposed to the forces of inflation."

Commenting on the relatively cheaper medical care prices today, Dr. John W. Cline, San Francisco, president of the A.M.A., said that "physicians recognize that the cost of medical care, especially hospital care, is a serious budget item for many persons. Therefore, the doctors are strongly supporting various voluntary pre-payment insurance plans to help meet these costs."

"The fact is, however," Dr. Cline continued, "that, as shown by official government statistics, medical care prices today, as compared with the prices of all goods and services, are relatively less than they were 15 years ago."

During recent years it has been variously estimated that between 85 and 90 per cent of industrial health services have been rendered by the general practitioner. In May, 1950 the American Academy of General Practice reported that a survey of their membership, developed the following information:

- (1) Industrial cases cared for by 95 per cent of their membership.
- (2) Average number of cases seen in 1948 was 234 per member.
- (3) About 20 per cent of the membership devote full time to industrial practice.

These significant facts led to the appointment of a joint committee by the Academy of General Practice and the Council on Industrial Health for the purpose of exploring the desirability of developing a joint program for the education of general practitioners in the fundamentals of industrial medical practice. This committee, meeting with representatives of the American Medical Association Section on General Practice, concluded that it is desirable to formulate a program and curriculum which will be implemented on a national, state and local level through joint cooperative effort of the participating groups.

"Dextrocardia Secondary to Foreign Body in Left Bronchus" was presented at the recent meeting of the Southern Medical Association in Dallas, Texas by Drs. Murdock Equen, Frank Buckner, George Roach and Robert Brown, all of Atlanta.

CORRESPONDENCE

October 12, 1951

To the Editor:

Our city is growing at a rapid rate and we have many new people moving here every week. Along with this general increase in population,

our city has inherited an abnormally high number of chiropractors and naturopaths and other quacks.

Our Medical Society is quite concerned over these people's ability to fool and misrepresent facts to the public. These particular men are making false claims, using large ads in the paper to illustrate "their 'success' after legitimate doctors failed," and in general are quite a threat to the less intelligent class of patients.

Two naturopaths are advertising in front of their establishments that they are in "General Practice." They have also applied to the Public Health Department for licenses in midwifery. We would like very much to prevent these men from being licensed along these lines if possible. Our Society would like very much to hear from you regarding any suggestions you have in controlling this group of men to the utmost, and would appreciate your opinion as to whether there is any way to keep these naturopaths from doing obstetrics.

I would also like to ask what steps the Public Relations Department of the State Society are taking in regards to the basic science bill in the legislature.

We feel here that our city is, more than the average one, being invaded by these quacks and would like any suggestions you have towards helping us to protect the people against them.

Sincerely,
Name Withheld

Atlanta, Georgia
September 18, 1951

To the Editor:

I want to congratulate you on the amount of publicity you have stirred up with regard to the situation at Milledgeville. I feel that the editorial in the *Georgia Journal* has done more to stir up newspapers to the problem there than anything else. I do hope you will be successful in bringing about an improvement in the situation. I refer of course to the screening of patients before their admission and also to the present situation whereby they must be committed by court. Keep up the good work.

With best wishes, I am

Cordially yours,
WALTER W. DANIEL

Malone, Florida
October 13, 1951

To the Editor:

As president of the Malone Lions Club, I am writing to you as editor of *The Journal* of the Medical Association of Georgia. Our Lions Club project for this year is to find a physician to locate in our town. We have an option on a large piece of ground in the heart of our town, on which is a huge building. We plan to remodel and renovate this house, make an office for a physician, and perhaps aid in equipping the office. Malone has

a population of 525, with a surrounding population of well over 2,000. Nearest hospital is in Marianna, which is 15 miles south.

Will you please assist us in interesting a physician in taking the place here in Malone with us? We need such a man in the worst kind of way.

Thanking you in advance for this favor, I am

Sincerely yours,
GAY A. RIMERT.

WOMAN'S AUXILIARY

The Bibb County Medical Auxiliary held its opening meeting of the year at the Sidney Lanier Cottage, with the president of the Auxiliary to the Medical Association of Georgia, Mrs. J. R. Shannon Mays, of Macon, as honor guest and speaker.

Sharing honors with Mrs. Mays were Mrs. Charles Hinton, Mrs. C. C. Harrold and Mrs. J. L. King, who are past state presidents of the auxiliary from Macon.

As the first meeting each year is the auxiliary's Membership Tea, at which time new members are welcomed, Mrs. Joe W. Daniel Jr., Mrs. Lon King, Jr., Mrs. J. T. Hogan, Jr., and Mrs. F. B. Meserve were welcomed by Mrs. Thomas L. Ross, Jr., president of the Bibb County Auxiliary.

Guests for the afternoon were wives of members of the house staff of the Macon Hospital and of Army and Navy doctors in Macon and Warner Robins.

HOSPITALS

Macon Negro physicians, apprehensive about Negro facilities in the projected \$5,000,000 addition to MACON HOSPITAL, last month received assurances that plans for doctor participation, a nursing school and greatly expanded Negro bed space will be carried through.

Interested Negroes, said Mayor Lewis Wilson, will have every opportunity to see architects' drawings and contractors' plans for the addition before they are adopted. A new wing for Negroes, with additional ward space and private rooms, and a Negro nursing school and dormitory probably will bring enough Negro patients to the hospital to necessitate placing Negro physicians on the staff, hospital officials have said.

A committee of Negro physicians has received what it called "satisfactory assurance" that Negro doctors will have full privileges to practice in the Negro section of the hospital, and the use of facilities.

The appointment of five physicians as consultants to the medical staff of MITCHELL COUNTY HOSPITAL, Camilla, has been announced by Dr. M. W. Williams, staff chairman. The consultants:

HEY, LEMME OUT OF HERE!

A man seeking treatment for a bellyache in Dahlonge these days had better think twice and watch his step, or there's no telling where he'll wind up.

As the result of a triple-play real estate transaction, this situation obtains in the north Georgia city: What used to be known as the "Dr. Craig Arnold house" is now a funeral home. And what used to be the funeral director's house is now a medical clinic. The buildings are situated across the street from each other.

It all came about when Bill Littlefield, Dahlonge's longtime funeral director, sold out to Hubert Vickers, who moved the business into the home of the late Dr. Arnold. Then Dr. Marcus Howard purchased Littlefield's house, in which he is setting up a 10-bed clinic.

To steer clear of the anticipated confusion, Littlefield moved out of town and took up residence on a farm.

Drs. Thomas Mack Sutton, pediatrics; J. Z. McDaniel, urology; Fred E. Murphy, orthopedics; Ernest Wahl, internal medicine; and Charles H. Watt, surgery.

The switchboard of the new HALL COUNTY HOSPITAL, Gainesville, is now serving nights, Sundays and holidays as a physicians' exchange. Through the cooperation of the Hall County Medical Society, which is paying for the cost of the service, and the Hospital Authority, physicians who are to be absent from their homes and offices leave word with the exchange as to their whereabouts. Patients receiving no answer on calling a doctor's office and home then call the exchange. If a physician leaves town, he gives the switchboard operator the name of another doctor who has agreed to handle his calls.

The SCREVEN COUNTY HOSPITAL, Sylvania, has obtained the part-time services of a radiologist and a pathologist. Dr. Jack Levy, of the staff of the Medical College of Georgia, spends each Thursday in Sylvania, doing any specialized x-ray work required. Dr. D. F. Mullins, Jr., Athens, does specialized laboratory work, with the specimens for examination usually being sent him by mail.

The maternity ward of ATLANTA'S GEORGIA BAPTIST HOSPITAL last month accepted an unusual patient: a male physician who has delivered some 2,000 babies. He was Dr. J. H. Hodges, of Hapeville, who sustained five broken ribs in an automobile accident on Highway 42 on October 14. Because no other beds were vacant, he was given a room in the maternity ward.

In spite of his pain Dr. Hodges enjoyed the situation, especially since he himself was "babied"

by nurses who through the years have ministered to scores of infants he brought into the world.

Five physicians and a dentist were admitted to the medical staff of SAVANNAH'S WARREN A. CANDLER HOSPITAL at a staff meeting held on October 16. They were: Drs. Irving Victor, urologist; Warren U. Clary, neuro-surgeon; Ernest Edwards, orthopedics; Hollis E. Puckett, internist; Vincent Circicioni, dermatologist; and Alexander Paderewski, dentist.

Charlie Brown, former Fulton County commissioner, was appointed a member of the FULTON-DEKALB COUNTY HOSPITAL AUTHORITY last month by unanimous vote of the Fulton County Commission. He succeeds Morgan Blake, Atlanta *Journal* columnist, who resigned because of poor health.

The new Screven County Hospital opened in Sylvania on September 9. Several days before, the staff of the hospital met and elected Dr. James Freeman as chief of staff and Dr. W. C. Simmons as staff secretary. It decided that the president of the Screven County Medical Society would also hold the office of chief of staff, and Dr. Freeman is current president of the Screven society.

MEDICAL SCHOOLS

Work is continuing steadily on the great Medical Research Building on the Emory University campus, the erection of which was begun more than a year ago. When completed, it will be the fourth building of the Emory medical school's on-campus medical center, the others being the John P. Scott Anatomy Building, the T. T. Fishburne Physiology Building and the Emory University Hospital.

Situated adjacent to the Hospital, the Medical Research Building will have a main section consisting of a basement and seven other floors and a wing consisting of basement plus five floors. Floor space will be roughly 125,000 square feet. However, for a time only half this area will be completed for use; the remainder will be occupied as funds for finishing it become available.

Located in the building will be the administrative offices of the School of Medicine, cancer research facilities, and the departments of biochemistry, medicine, surgery, pathology and radiology.

A National Cancer Institute grant of \$500,000 is being used to provide the cancer research facilities in the structure. The other funds for its erection are being obtained from private sources.

Dr. G. Lombard Kelly, president, Medical College of Georgia, attended the recent meeting of the Association of American Medical Colleges at French Lick Springs, Indiana.

Dr. J. G. Bohorfoush, chief, Professional Services, Veterans Administration Hospital, Augusta Annex, has been appointed associate professor of clinical medicine at the Medical College of Georgia, effective October 1. Prior to his arrival in Augusta, Dr. Bohorfoush was chief of professional services, Veterans Administration Hospital, Memphis, Tennessee, and held the title of assistant professor of medicine at the University of Tennessee, Memphis.

Physiology seminars convened at the Medical College of Georgia on November 9 and 10. This marked the formal opening of the new \$58,000 heart laboratory which was erected through a grant of funds from the National Heart Institute.

Guest speaker on November 9 was Dr. E. M. Landis, professor of physiology, Harvard University, and president-elect of the American Physiological Society, who lectured on "Cardiac and Extracardiac Factors in Congestive Failure of the Circulation".

On November 10, the following physiologists, among others, participated: Dr. T. G. Bernthal, Medical College of South Carolina; Dr. Hampden Lawson, University of Louisville; Dr. H. S. Mayer-son, Tulane University; Dr. C. W. Sheppard, Oak Ridge National Laboratory; and Dr. J. V. Warren, Emory University. Subjects discussed at the day's seminars were "Capillary Physiology and Fluid Balance" and "Dye Injection Curves."

Dr. W. F. Hamilton Jr. is head of the Department of Physiology at the Medical College of Georgia.

Twelve members were added to the faculty of the Emory University School of Medicine and 13 other teachers received promotions as the 1951-52 academic year got under way. At the same time two resignations were announced.

The new faculty members are: Drs. Morris Schaeffer, associate professor of bacteriology and immunology; Mary Gilliland Dorrough, instructor in pediatrics; Frank W. Fales, instructor in biochemistry and biochemist of the Clinical Laboratory at Emory University Hospital; Brinton B. Gay, Jr., instructor in radiology; Glenville A. Giddings, assistant in medicine; George Robert Gish, Jr., assistant in surgery (neuro).

Drs. Haywood N. Hill, assistant in medicine; Thomas Adolph Harris, assistant in obstetrics and gynecology; William D. Jennings, assistant in anatomy; David Smyth McKee, assistant in pediatrics; James Buren Sidbury, assistant in pediatrics, and Clyde E. Tomlin, assistant in medicine.

Those promoted, with their new ranks, are: Drs. James V. Warren, professor of medicine (Dr. Warren at the same time resigned as professor and chairman of the department of physiology and will devote full-time to teaching in medicine); Richard W. Blumberg, assistant professor of pediatrics; Joseph H. Patterson,

assistant professor of pediatrics; Stephen T. Barnett, associate in obstetrics and gynecology; Rives Chalmers, associate in psychiatry; Richard Arthur Elmer, associate in radiology.

Eugene L. Griffin, associate in obstetrics and gynecology; William H. Grimes, associate in obstetrics and gynecology; C. Dixon Fowler, associate in pediatrics; Albert A. Rayle, Jr., associate in radiology; Ellen Finley, instructor in psychiatry; Robert H. Gillespie, instructor in obstetrics and gynecology, and J. Harry Lange, associate in pediatrics.

Those offering resignations were Dr. Franklin H. Goodwin, assistant in medicine, who is leaving Atlanta, and Dr. Warren B. Mathews, associate professor of pathology, to devote full time to his patients.

Members of the State Board of Health and of the State Commission on Alcoholism held a conference October 24 in the office of Dr. G. Lombard Kelly, president of the Medical College of Georgia, to consider plans for hospitalizing patients under the proposed program authorized by the Legislature last winter. Others present were Mr. Wilfred Gregson of Gregson and Ellis, architects, Atlanta; Dr. Herman Smith, hospital consultant, Atlanta, and Drs. Rufus Payne and Kelly.

The World Health Organization has awarded Dr. Albert Heyman, assistant professor of Medicine in the Emory University School of Medicine, a fellowship to visit England and Sweden to study the methods employed in European medical schools in teaching environmental factors in medicine. He left Atlanta on September 15 to visit medical schools in London, Oxford, Edinburgh, Wales and Stockholm over a period of two months. This fellowship is part of a newly organized program sponsored jointly by Grady Memorial Hospital, the Georgia Department of Public Health and Emory University for the study and teaching of the community and environmental factors influencing the course of disease. Dr. Heyman has been invited to address the Medical Society for the Study of Venereal Diseases while in London.

Medical schools of the United States in the last year took further steps to protect the future health of the nation by enrolling the greatest number of students in their history.

This was revealed recently in the 51st annual report on medical education in the United States and Canada, compiled by the Council on Medical Education and Hospitals of the American Medical Association.

A total of 26,191 students were enrolled in 79 approved schools in the United States for the 1950-51 academic year. This compares with the previous high record of 25,103 in the year before, an increase of 1,088 (4.1 per cent). Since 1941, when there was an enrolment of 21,379 students

in 77 approved schools, the increase has been 4,812 (22.5 per cent).

The report also disclosed that the present academic year will see a continuation of this increase in medical education because of the enrollment of a record freshman class. It is estimated that about 7,400 new students entered medical schools this fall, compared with the previous record of 7,182 a year ago.

Also important from a future health protection standpoint was a survey which showed plans were under way in many states for the opening of additional medical schools and for the expansion of existing facilities.

Also important from a future health protection standpoint was a survey which showed plans were under way in many states for the opening of additional medical schools and for the expansion of existing facilities.

"Significant progress is being made toward resolving the financial problems of the medical schools," the report also said. "Funds available to the schools during 1951-52 will total approximately \$109,600,000, which represents an increase of \$36,000,000 in the last four years. In addition to the usual sources of funds, the schools this year are receiving grants from the National Fund for Medical Education and the American Medical Education Foundation. However, serious financial problems remain for a number of schools."

There were 6,135 physicians graduated last year, as compared with 5,553 the year before. In the seven years before World War II, the annual graduations from approved schools ranged from 5,089 to 5,377.

Negro students enrolled in 46 United States schools totaled 2.5 per cent), compared with 647 (2.6 per cent) the year before in 42 schools.

The schools estimated that about \$16,300,000 (21.9 per cent of budgets) will come from tuition fees. Last year, tuition fees provided \$15,200,000 (22.5 per cent). The remainder of their requirements will come from other sources, including endowments, grants and gifts.

The report cited the widespread interest in the development of new medical schools. The University of California at Los Angeles this fall was admitting its first freshman class, two years earlier than originally planned. Mississippi was expected to break ground soon for a four-year school. West Virginia is preparing plans for a school at Morgantown. New Jersey was expected to call a special session of the legislature to locate a new school and to provide for its financing.

Plans also were under consideration in Rhode Island, Massachusetts, Florida, Missouri, New York City and elsewhere.

Two Emory University School of Medicine professors presented papers at the Kentucky State Medical Association Centennial on October 2-4. Dr. Daniel C. Elkin, Whitehead professor of surgery and chairman of the department, discussed

fistulas and Dr. Robert P. Kelly, associate professor of surgery (orthopedics) and chairman of the section of orthopedics, spoke on ankle injuries.

Dr. Perry P. Volpitto, professor of anesthesiology at the Medical College of Georgia, addressed the American Society of Anesthesiologists on November 8 at its annual meeting in Washington, D. C. Dr. Volpitto is second vice-president of the society.

Dr. Peter B. Wright, of the Medical College of Georgia, immediate past president of the Georgia Chapter of the American College of Surgeons, this month has attended the clinical congress of the College of Surgeons in San Francisco, Calif. and the meeting of the Pan-Pacific Surgical Association in Honolulu. Dr. Wright is a member of the trauma committee of the College of Surgeons. In Honolulu he gave a paper and presented an exhibit on Paget's disease.

PUBLIC HEALTH

Physicians, Dentists Briefed on Health Set-Up

When members of the Medical Association of Georgia and the Georgia Dental Association met with officials of the State Department of Health in Atlanta on Thursday, October 11, the occasion represented one of the first positive steps toward establishment of a mutual understanding and closer working liaison among the organizations.

Specifically bidden to the October 11 meeting by Dr. T. F. Sellers of Atlanta, director of the Georgia Department of Public Health, were members of the Committee on Public Health of the Medical Association of Georgia, together with the district and county society sub-committees, and the corresponding groups in the Georgia Dental Association.

The conference was held in the auditorium of the Life Insurance Company of Georgia at West Peachtree and Linden Streets and was called to order by Doctor Sellers at 10 a. m., with Dr. Lee Rogers, of Gainesville, as presiding officer.

The first official to be introduced, and to whom much verbal tribute was paid, was Dr. T. F. Abercrombie, of Atlanta, under whose untiring leadership the Georgia Department of Public Health has received national recognition for the development of one of the finest public health programs in the country.

The meeting then got under way with the introduction of the divisional directors of the Department, each of whom gave a five-minute resume on the organizational set-up and the work and objectives of his division or subdivision of the Public Health Department.

Participants and their topics of discussion on the program included: Dr. R. F. Payne, Battey Hospital; Dr. W. J. Murphy, Cancer and Epidemiology; Dr. Edgar M. Dunstan, Civil Defense; Dr. Guy V. Rice, Crippled Children, Maternal and

Child Health, and Mental Hygiene; Dr. J. G. Williams, Dental Health; Mr. L. M. Clarkson, Environmental Sanitation; Dr. C. D. Bowdoin, Health Education and Heart Disease, and Dr. R. C. Williams, Hospital Service.

Also giving presentations were Dr. L. M. Petrie, Industrial Hygiene; Dr. S. C. Rutland, Local Health Organizations; Miss Theodora A. Floyd, Nursing; Mr. H. M. Chester, Personnel; Dr. L. E. Starr, Rabies; Dr. H. C. Schenck, Tuberculosis Control; Mr. R. J. Boston, Typhus and Rodent Control; Mr. L. M. Lacy, Vital Statistics, and Mr. W. H. Weir, Water Pollution Control.

A final check on the registration indicated that the Medical Association of Georgia was represented by members from all areas except the Second Councilor District.

BOOKS RECEIVED

AN ATLAS OF NORMAL RADIOGRAPHIC ANATOMY: By Isadore Meschan, M.A., M.D., Professor and Head of the Department of Radiology, University of Arkansas School of Medicine. With the assistance of: R.M.F. Farrer-Meschan, M.B., B.S., (Melbourne, Australia). 593 pages, 1044 illustrations on 362 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price \$15.00.

PSYCHOSOMATIC GYNECOLOGY: Including Problems of Obstetrical Care: By William S. Kroger, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, Chicago Medical School; and S. Charles Freed, M.D., Adjunct in Medicine, Mount Zion Hospital, San Francisco, California. 503 pages. Philadelphia and London: W. B. Saunders Company, 1951. Price \$8.00.

PEPTIC ULCER—Clinical Aspects—Diagnosis—Management: Editor, David J. Sandweiss, M.D., F.A.C.P., Associate Attending Physician, Division of Internal Medicine, Harper Hospital, Detroit, Mich.

Editorial Committee, A. H. Aaron, Henry L. Bockus, George E. Daniels, George B. Eusterman, L. Kraeer Ferguson, A. C. Ivy, Sara M. Jordan, Frank H. Lahey, Walter L. Palmer, Harry Shay, Albert M. Snell, Dwight L. Wilburn. 790 pages with 164 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price \$15.00.

AMERICAN MEDICAL ASSOCIATION

MEDICAL STUDENT SCHOLARSHIPS. For a long time the A.M.A. through its Committee on Rural Health and its component societies, along with the nation's medical schools, has been working on a variety of scholarship plans to help solve the doctor shortage in many rural areas.

A promising approach has been to finance the

education of local boys who agree to spend a specified number of years in rural practice in their native states.

There are many variations of such scholarship plans in effect in all sections of the country today, according to a preliminary study now under way by the A.M.A.'s Physicians Placement Service.

The study points to the activities of medical societies and medical schools in the redistribution of physicians to help the rural areas. It covers the progress that has been made in establishing loan funds, preceptorships, and postgraduate programs in the different states to interest prospective students in developing a taste for rural medical practice.

The study, while not complete, tends to show that the comfortable roominess and warm friendliness of the farm and small town can match the dollar appeal and the cultural advantages of the crowded cities.

A few of the loan and scholarship plans have been in effect long enough now so that some of the students are actually out of school and are practicing in the rural areas.

At least 11 states, the survey shows, have some type of student loan or scholarship fund requiring rural practice.

In addition, six other states have a type of loan or scholarship fund that encourages rural practice but does not require it. Medical schools in 11 states also offer courses of special interest to the rural or general practitioner. Medical schools and hospitals in 15 states have rotating internships or residencies in conjunction with rural hospitals, while medical schools in 16 states offer preceptorships under a general practitioner.

HALF THE POPULATION COVERED. The Health Insurance Council, made up of nine trade associations in the life and casualty fields, recently came up with its 1950 report which shows that at least half of the nation's population at the end of last year was covered by one type or other of voluntary protection against the economic hazards of sickness and accident.

All forms of voluntary health protection scored tremendous gains in 1950 to set new records. Hospital expense protection, which covers the largest number of people, was extended to 76,961,000 persons at the close of 1950. This total was 17 per cent greater than the figure of 66,044,000 just a year before.

Growing public appreciation of the advantages of voluntary health protection can be seen in the fact the number of people protected against hospital costs has more than doubled since the end of World War II.

Great strides also were made by surgical expense and medical expense coverages in 1950. Protection against surgical expense was provided to 54,477,000 persons at the end of last year as compared with 41,143,000 a year earlier, or an increase of 32 per cent. A year-to-year gain of 28 per cent

was recorded by medical expense protection which covered 21,589,000 persons in 1950 and 16,862,000 in 1949.

Both surgical and medical coverages also have shown larger postwar gains, with the 1950 number of persons in each case being more than quadruple the 1945 totals.

The A.M.A. Council on Medical Service has received a supply of the complete insurance report and will mail it to any physician requesting it.

STUDENT A.M.A. TO PUBLISH JOURNAL. The first issue of a 72-page *Journal of the Student Medical Association* will be out in January.

Published monthly, except July, August and September when the schools are closed, the magazine will have a circulation of more than 33,000. It will be sent to 26,191 medical students and to approximately 7,000 interns. The S.A.M.A. *Journal's* contents will be about one-half text and one-half advertising. Dr. G. Lombard Kelly has been named as senior adviser.

The publication will make it possible for the Student American Medical Association to "provide the young doctor with a broader realization of the socioeconomic aspects of medicine."

"It will demonstrate," said Executive Editor Russell F. Standacher, "to tomorrow's doctors their duties and responsibilities not only as physicians but as citizens in their respective communities. It will also show the young doctor why the nation's medical schools need his enthusiastic support to continually improve medical education."

FIREWORKS BAN SUPPORTED. The American Medical Association has filed a statement with the House Judiciary Committee supporting its bills restricting the sale of fireworks.

The statement said that the medical profession for many years "has been concerned with the serious menace to life and health resulting from the use of fireworks." It added that the Association is in favor of proposals such as the bills under consideration, "which are designed to alleviate health hazards of this type."

The bills would prohibit the shipment of fireworks into any state or political subdivision in which their sale is prohibited, unless intended for public displays or other purposes specifically authorized by law.

WASHINGTON NEWS

The National Federation of Independent Business, claiming a membership of 100,000, voted by a big majority against the government's providing free medical care for all persons over 65. The vote was 84 per cent against.

The poll grew out of a plan being promoted by Federal Security Administrator Ewing for the government to pay the cost, up to 60 days a year, of care in a hospital for persons 65 and older who are covered by old-age and survivors insurance

of the Social Security system. Their dependents also would be covered.

The Christian Science Monitor published an excellent editorial based on the federation's poll. The editorial included the following comment from Edward Wimmer, Cincinnati, vice-president of the federation:

"It may be charged that the overwhelming opposition to this 'free' medical care for people over 65, as expressed by our members, indicates a heartless attitude toward the suffering of the aged. This is not true. The officials and members of the National Federation of Independent Business are just as charitable in their thinking as the sponsors of these 'free medicine' bills.

"What we see in such recommendations is another dose of political medicine, concocted with the idea of furthering the myth that government has the answer to all our ills.

"Government does have social responsibilities, and the health of the people is one of those responsibilities. Witness the control over narcotics, contagious diseases, the policing of industry by the Pure Food and Drug Administration, the laws governing sanitation, pasteurization and other protective measures.

"These are all necessary government functions. In that vigorous policing is necessary. But in this issue of so-called 'free' medical care for the aged, government steps into a role that is far afield from its original premise.

"What we have here is the old issue of whether the people shall maintain and improve self-care under private and local initiative, or whether the state is to administer over all. We are getting dangerously close to the latter in that millions of Americans are already hypnotized into believing that whatever they want can be rendered from Washington.

"At present, there are many people over 65 who are in desperate need of proper care, but the same can be said about millions of children and other age groups.

"I think these needs are being recognized, and in the expansion of voluntary insurance programs and in other ways, the American people are accepting their responsibilities and exercising the individual initiative that made us a great nation.

"By confining the problems of health care to local initiative, wherever practical and possible, we develop socially, economically and politically, under the conditions of freedom, and I do not believe there are any persons in America today who cannot get medical attention if they go through the proper channels.

"The people all over the world have been getting so much political medicine they are sick of it. There has been, and will continue to be, great progress made in this country in the field of public health, and largely under our system of local initiative and free enterprise. Let us keep it that way."

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Editorials

THE CHRISTMAS SEASON

"My best of wishes for your merry Christmases and your happy New Years, your long lives and your true prosperities. Worth twenty pound good if they are delivered as

I send them. Remember! Here's a final prescription added 'To be taken for life'."—Charles Dickens, DOCTOR MARIGOLD, Chapter 1.

It is always difficult for anyone past the Santa Claus age to think of Christmas as a single day, but rather as a season filled with good cheer, social events, the exchange of gifts, and a tremendous climax when there comes a visit from the jolly old gent and a happy family dinner. Back of all this runs the true theme of the Christian observance of the nativity of Christ and its profound influence on the events in the world during the past two centuries.

The Medical Association of Georgia approaches this holiday season with serious contemplation of its increasing activities and responsibilities in the field of organized medicine, and with deep appreciation for the cooperation it is receiving from its members. The troubles and tribulations that

beset the entire country today are reflected in all organizations and the Association has become more aware of the job that is expected of it, the successful accomplishment of which will be dependent on the continued support and endeavors of each member.

A gift to the members of the Association will be a new *Journal*. Beginning with the January number, the page-size will be increased slightly to conform with advertising requirements, and a new cover has been designed. The format, in general, has been changed to improve readability and interest. It is hoped that all changes will meet with your approval. Your comments and contributions are invited. It is reiterated that *The Journal* is no better than you, as a member, make it.

WHAT ABOUT OBESITY?

According to recent press reports, obesity is the number one problem facing the medical profession today. The well known relationship between overweight and diabetes, and the life insurance statistics proving that obesity definitely shortens life expectancy, forces us to face this problem. The real problem is how to satisfy these patients' appetites, and at the same time keep them in good physical condition by providing the essentials of diet for health with low caloric value, and make them like it.

Is all obesity due to gluttony? Not all, perhaps, but most of it is. We must admit that obesity may be caused by myxedema, hyperinsulinism, and other well recognized glandular disorders as Cushing's disease, etc. but these are relatively few in number. However, regardless of the cause, the caloric intake exceeds the caloric consumption in the obese individual.

Nervousness has been shown to be a cause of obesity by driving the patient to eat merely to be doing something, and not from hunger but from boredom. An insatiable appetite in an otherwise normal person could be due to an overactivity of the medullary center or its accessory center in the cortex. Factors which stimulate these centers are not well understood, but it is probable that they are influenced by the sympathetic nervous system.

The treatment depends upon the cause, yet it must include also a scientific attack upon the diet. For example, a hypothyroid obesity will reduce on thyroid therapy alone, but will do better when taking thyroid plus a regulated, sane, dietary. All cases of obesity must be re-educated as to their diet.

The basic requirements for a reduction diet are: low caloric value with a high protein content (at least 1 gram per kilo body weight), low fat content, low carbohydrate content and high vitamin values, especially in vitamins A, B, and D. With the fat soluble vitamins supplied in high percentage together with B₁, the diet may safely omit bread and butter. The protein should be derived from both animal and vegetable sources. Furthermore, the diet should be palatable, easy to prepare and easy to take. It must be easily assimilated, satisfying to the appetite and chemically pure.

It is practically impossible in this day of busy patients to get them to follow a specially weighed or measured diet for any great length of time. Experience has shown that the best results follow the use of the simplest rules and formulas.

The medical profession is tending toward the use of prepared food supplements in simplifying the diet. For a number of years there have been several such preparations available. Recently a new preparation of food supplement* has appeared

to meet all the basic requirements especially in regard to solubility, palatability and potency. In clinical use it satisfies the appetite and gives the patient a lift. Experience in a series of over 200 patients has shown that this supplement causes a satisfactory loss of weight and combines well with appetite depressants.

The rate of weight loss is important. In the first month the loss may be 10 to 30 lbs., because much of this is fluid weight. After the first month the weight reduction should be maintained at 5 to 8 pounds per month. The reason for this slow reduction is two-fold: first the patient must be re-educated regarding the proper foods to eat and the times to eat, and secondly, the skin must be given time to contract over the space where the fat is lost. A too rapid weight loss will result in a haggard, wrinkled appearance of the skin, whereas a slower weight loss will result in a smooth soft skin which will leave no tell-tale marks showing previous obesity. Rapid weight loss is desirable only at the beginning of treatment to give the patient a morale boost in order to encourage him to continue treatment. Too rapid loss may result in ill health and anemia. Another reason why slow reduction is considered desirable is to enable the physician to hold the weight at or near the ideal for a period of weeks before letting up on the treatment. This insures a more permanent result. This is further insured if the patient has been thoroughly educated as to his diet. At the end of treatment, he should be able to go anywhere and be able to select enough food to maintain a normal weight.

The use of appetite depressants is very common and they tend to be habit forming if continued for long periods of time. Only one of the various brands tested showed no ill effects such as lowering the blood count. If such drugs are used they should be given intermittently and continuous therapy may result in nervousness, insomnia and even a gain in weight. Such symptoms call for immediate cessation of drug therapy for a period of weeks or months.

The diet must be regulated as to the age and activity of the patient. If the weight is not too far above normal, the use of a food supplement once a day in place of a meal is sufficient. The noon meal is easiest to omit. If more weight is to be lost, the dietary supplement may be used twice or three times a day. A suggested dietary is: breakfast—one scrambled or poached or boiled egg, one slice bacon, food supplement, fruit juice, clear tea or coffee. Lunch—food supplement, soup, crackers, fruit. Supper—regular meal omitting bread and dessert. If there is a let-down in the afternoon, another dose of food supplement is given in some fluid. This regimen gives the best results with the least effort.

*The food supplement mentioned above is manufactured by Tablerock Laboratories under the name Vicaltein.

Constipation is always a side effect of dietary restriction. It should be rectified by laxative foods such as fruits and vegetables and gelatin foods. If necessary, a mild laxative may be used occasionally.

The obese patient is a problem because he needs help. He has no will power, and will admit

it. We cannot hand him a diet and expect him to follow it. Neither can we give him a pill and let him go. He must be re-educated along dietary lines and shown how to eat and yet not get fat again. This can be done if the doctor will be patient with his patient.

J. KENNETH FANCHER, M.D.

V OUR TWENTY-FIVE DOLLARS

Council on Pharmacy and Chemistry With Its Various Committees:

- Chemical Laboratory
- Therapeutic Trial Committee
- Therapeutic Research Committee
- Bureau of Investigation
- Committee on Cosmetics
- Committee on Pesticides

One of the first questions to come before the AMA Convention after its organization in 1847, was the regulation of drugs, patent medicines, and proprietary remedies. In those days quack remedies, drug adulteration, and erroneous advertisement were rampant. Drugs were sold to cure anything from falling hair to ingrowing toenails.

The word "drug", its origin uncertain, has several meanings. It is defined as a substance used as a medicine. Even today the action of many drugs is uncertain and their end results are variable. Another definition of "Drug" is as an unsalable article—"a drug on the market." The public would be better off financially and healthier if all the patent medicines would become "a drug on the market." Primitive belief in the magic of medicine is still deeply rooted in human nature. Patent medicines are sold the world over—to the poor as well as to the well-to-do; to the ignorant as well as to the educated. Self medication, person to person medication, over the counter sales, and protests against protective vaccination and immunization are seen and heard every day.

Modern medical science has made many parts of the world, and especially our cities and towns, a convenient place in which to live. If preventive medicine were lost; if drinking water were no longer purified; if sanitary disposal of sewage were discontinued; if vaccination and immunization were omitted, disease would spread rapidly and epidemics would sweep across the country, making many sections of our nation uninhabitable. Medical protection has made modern civilization. We must not forget that we are no more immune from pestilence than the people of the middle ages. If we were deprived of the protection of medical science, civilization would be thrown back hundreds of years.

The Council on Pharmacy and Chemistry with its many subcommittees is constantly conducting tests, experiments, and investigations against patent medicine, quackery, fraud, hidden drugs, un-

true advertisement, and other devices in order to protect the physicians and the public against fraudulent products. It is impossible for physicians to keep up with the action, risk, and usefulness of all the drugs and devices on the market today. We can limit our remedies to council accepted products. We can be sure of their purity and standardization. We certainly cannot afford to use drugs with which we are not familiar. Never in the history of the world have physicians had a more remarkable armamentarium with which to practice medicine than today. The Council on Pharmacy and Chemistry keeps the physician informed on those new drugs in the pages of the J.A.M.A. and in its book, *New and Non-Official Remedies*. This council has been the guiding factor in the enactment of the laws—both Federal and State—in the control of patent medicine, drugs, and other remedies. John R. Brinkley, "the greatest charlatan of modern times," was finally driven out of this country and eventually destroyed through the persistent work of the AMA. He is only one of the hundreds of quacks which the AMA has destroyed and brought to justice. You have to read the Council's report in the J.A.M.A. of October 27, 1951 on "Krebiozen" in the treatment of cancer to see how thorough they are in their work.

The chemical and bacteriologic laboratory is fully equipped for all kinds of chemical investigation of therapeutic agents. Often they are called upon to find a hidden drug in patent medicine. The laboratory checks purity and potency of drugs, chemical and physical properties of drugs and pharmacy of therapeutic agents.

The Therapeutic Trials Committee and the Therapeutic Research Committee are devoted to encouragement of research on medical agents and are organizers of impartial clinical tests on drugs and biological agents. They sponsor research funds and clinical investigation involving several institutions. The Committee on Cosmetics was organized in 1948 to provide information on toilet goods and cosmetics. It evaluates and approves cosmetics that conform to its rules. The Committee on Pesticides was formed in 1950 for the study of insect and rodent poisons, as well as fungicides, rodenticides, and herbicides.

The Council on Food and Nutrition was organized in 1929 to study claims on food and nutrition.

Foods are appraised and tested for truthfulness of advertisement and as to purity and quality of ingredients. The approved foods are given a Seal of Acceptance, thus encouraging high standards for food products both as to contents and advertisement.

The Council on Physical Medicine and Rehabilitation evaluates therapeutic and diagnostic devices. Its work has increased to such an extent and the field of usefulness has widened so much that it has employed a full time physician as secretary. In the near future a complete physical laboratory will be established at AMA headquarters for improving the testing of devices.

These councils and committees, in addition to evaluating drugs and therapeutic and diagnostic methods, encourages the training of more occupational and physical therapists, improvement in treatment at rehabilitation centers and health resorts, and many other methods and devices for the improvement of health and restoration of the handicapped to useful service.

At no time has the work of these councils and

committees been easy. The responsibility is heavy and always increasing. All ethical drug houses and cosmetic producers are anxious to secure the "Seal of Acceptance." This seal is never given without a thorough unbiased study of the product and a complete cooperation on the part of the manufacturer. This seal carries so much obligation that the council must be sure of its work. A breakdown anywhere along the line could cause disaster to the patient and the physician. The physician dispensing the end product does not take the time to consider the amount of research, testing, clinical trial, and double checking before a product is approved for *New and Non-Official Remedies* or for the Seal of Acceptance.

The prestige of the Council has grown through the years and other countries have established similar organizations. The Council cooperates with the Federal Food, Drug, and Cosmetic Department and the Bureau of Chemistry.

These services alone are worth more to the physician and his patients than the mere dues paid to the AMA.

EUSTACE A. ALLEN, M.D.

CHRONIC ALCOHOLISM SYMPOSIUM

Too few physicians today recognize that chronic alcoholism represents an illness readily responsive to proper medical treatment and rehabilitation.

Chronic alcoholism today is purported to be the fourth major health problem in the nation, the solution to which will require active participation by the so-called family doctor.

In its recent report to the Governor, the Georgia Commission on Alcoholism revealed the presence in the state today of more than 50,000 known sufferers and indicated that chronic alcoholism is on the increase, particularly among women and adolescents.

Realizing that physicians adequately may utilize briefing on up-to-the-minute methods of treating and rehabilitating the alcoholic, the Georgia Commission on Alcoholism has scheduled an outstanding symposium on the subject at Taft Hall,

City Auditorium, Atlanta, on Friday, January 18, 1952.

Each of the five guest speakers to appear on the symposium has attained national prominence in the field of alcoholic treatment and rehabilitation. They include Ebbe C. Hoff, M.D., Ph.D., member, Royal College of Surgeons, England and Medical Director, Virginia Program on Alcoholism, Virginia Medical College, Richmond, Va.; Raymond G. McCarthy, M.A., M.Ed.; Leon A. Greenberg, Ph.D., and Ralph M. Henderson, LL.B., all of the Clinic on Alcoholic Studies at Yale University, New Haven, Conn., and Charles L. Allen, D.D., Grace Methodist Church, Atlanta.

Members of the Medical Association of Georgia are invited to attend the symposium and owe it both to themselves and their patients to do so.

THE SURGEON IMPROVES HIS ETHICS

The American College of Surgeons last month asked the profession to be more considerate about charging patients for operations.

Surgeons should consult "more freely" with the patient's family doctor about the ability of an individual to pay for his operation, said a report approved by the college's board of regents.

The surgeon also should talk over finances with the patient before the operation, the report added. "Ghost surgery," one of several forms of fee-

splitting among doctors, drew a specific note of disapproval from the regents. In this procedure the patient's regular doctor pays the surgeon for performing the operation. The surgeon may remain unknown to the person upon whom he operates and the patient may be led to believe the family doctor did the work, the regents said.

As in years past, the regents also condemned other forms of fee-splitting.

Scientific Articles

CONTRIBUTIONS OF PRESENT DAY PSYCHIATRY TO THE ROLE OF THE MEDICAL PRACTITIONER

RIVES CHALMERS, M.D., Atlanta

PRESENT day psychiatry is established as an important specialized branch of medical science. It deals with forces within the individual which we call emotions, or feelings, and these forces have no physical characteristics which we can measure, except in terms of our own emotional experience. Our whole field of operations is confined to the various expressions of emotion which we are able to observe in the individual. This means that we are dealing with emotion which is felt and expressed by one individual, and perceived and recognized by a second individual. We are, therefore, dealing with the process by which one individual relates his whole emotional self to another individual. We find ourselves dealing, not with one individual in a vacuum, but with the manner in which one individual relates to another individual, and we have come to define psychiatry as the science of interpersonal relationships. It is well recognized that, at the present time, there is a great deal of art, individual creative expression, involved in this science which we call psychiatry. This will always be the case, because it is not possible to define all the constantly changing aspects of human relationships.

In psychiatry we find ourselves facing more clearly the fundamental conflict which all of us experience in the practice of medicine. Our goal is the health of the individual, and yet we find that it is not possible for us, as human beings, to make any other human being healthy. We find that we can exert all of our efforts toward the eradication of disease, and the promotion of factors necessary to health, but we can never reproduce the healing process itself. Prior to the advent of psychiatry it was felt that mental illness, and the so-called functional disturbances, represented fundamental defects in

the individual which could not be eradicated by treatment, and consequently there was no concept of a healing process within the emotions. This attitude prohibited any positive approach to treatment of emotional disturbances, and the whole attitude of physicians was the same as that of other members of society, in rejecting the individual who suffered with an emotional disturbance. This attitude brought about the attitude which we still find being expressed in many quarters today. The person who is mentally ill is criticized for his behavior, and exhorted to forget his unusual ideas, and unusual feelings. This same approach leads to the labeling of neurotic symptoms as imaginary.

Today it is definitely recognized that so-called neurotic symptoms are just as real to the person who suffers with these symptoms, as is the pain of labor to the woman having a baby. The tightness, or knot in the throat, characteristic of globus hystericus, is just as real as the sensation experienced by a person who attempts to swallow a large bolus of food, and feels it lodged in the throat. The so-called functional headache is just as real as the headache of a brain tumor. These symptoms cannot be dismissed by the term "imaginary", and we are not fulfilling our function as a practitioner of the healing art when we tell the patient that there is "nothing wrong." Psychiatry affirms, with positive evidence, the fact that mental disease and functional illness have a definite pathology, and are amenable to positive treatment. The pathology usually develops in the basic attitudes and patterns of response established during the first few years of life. We find that the human organism organizes its response to other humans in terms of its experience with those humans. Just as we recognize a physical growth process to maturity, we also recognize an emotional process of growth to maturity. Just as the physical process is altered by factors in the

physical environment, in the same way the emotional process is altered by factors in the emotional environment. There is some research which indicates that the emotional responses of infants begin in utero. We all know that emotional responses are present from birth, and we recognize that these responses become altered and patterned according to the attitudes of those individuals close to the child. I am sure that we have all seen the baby who has feeding difficulties because of the mother's anxiety, or children who cry all of the time because of the anxiety present within the parents. We are not so quick to recognize the child who does not cry at all because of the total lack of emotional feeling in the parents. We accept as natural the pleased and satisfied expression of the child who receives the proper love and attention from its parents.

The child first develops attitudes toward the significant parts of its own physical self, such as the mouth, body, and later the anus and genitourinary apparatus. As the child develops this concept of himself as a separate, distinct personality, he begins to relate himself to the other significant personalities in his emotional environment. This process of relating himself to other significant individuals will continue throughout his life, but we find that the individual who establishes health yrelationships with significant individuals in childhood is able to use these experiences in establishing satisfying relationships later on in life.

We have viewed psychiatry as the science and art of inter-personal relationships. We have viewed psycho-pathology as pathology in the basic attitudes and responses of the individual in his inter-personal relationships. In this same manner, we define psychotherapy as a special type of inter-personal relationship directed toward the eradication of psycho-pathology, and the promotion of healthy attitudes and responses within the individual. This relationship is the relationship which every doctor wishes to establish with his patient.

It is the purpose of this paper to consider the role of the doctor in the doctor-patient relationship, with special emphasis on the special application of psychiatric knowledge to this role.

We, as physicians, realize that the various members of society have a multitude of conflicting attitudes about our functions and

responsibilities. They do not think of us as human beings, like themselves, but rather as superior beings, having wide knowledge and almost divine skill and patience. They do not wish to recognize our own inadequacies, and in many instances they tend to misuse our own inadequacies to destroy themselves.

The doctor-patient relationship is a special form of inter-personal relationship, structured by the individual physician, and directed toward the relief of suffering and promotion of health within the patient. Psychiatric experience teaches us that the more clearly we are able to define the structure of our relationship with the patient, the better he is able to use this relationship for his own good. This implies that we are merely establishing ourselves as part of a structure, or tool, which the patient may use to satisfy his own needs. We give definition to our own role by all of our expressions to the patient. The time and place of original consultation, our own specialty or special branch of interest in the patient, the questions we ask, and observations we make, including physical and laboratory studies, our charges to the patient, our diagnosis and therapeutic recommendations, are all clear cut aspects of our role as a physician, which we can express directly to the patient. So many times I find people who want to withhold information from a patient, or fail to recognize the need for giving information to a patient, and I feel that these individuals always contribute to the confusion of their patients. In many instances, individuals hesitate to tell patients they are referring to me, that I am a psychiatrist. When the patient arrives at my office he is very much disturbed to find that he has been misled, or has not been informed as to the reason for his seeing me. He immediately feels that the person who referred him has let him down. Many times we hesitate to discuss the details of financial arrangements, because we are more interested in rendering the services required by our patients. We do not realize that the patient is the one most immediately concerned about the financial arrangements, and he will probably avoid this discussion until the physician brings it up.

It is important that we always speak the language which our patients understand, and not confuse them with terms they do not understand. In carrying out diagnostic procedures, it is well to let the patient know the

purpose of the procedure, or at least something of the nature of the procedure, in order that he may feel that he is cooperating in an experience, rather than being a guinea pig. When the diagnosis is made, it is well to explain this to the patient in such a manner that he can understand it.

There is a prevalent attitude among the physicians of today that it is best not to inform patients of hopeless prognosis, and they side-step this obligation by informing some responsible member of the family, and telling the family that they do not feel it right to bother the patient with such knowledge. This is a very immature and unreal approach to the physician's responsibility to his patient, and it places a load of responsibility on the family, which is far out of keeping with the reality of the situation, and denies them the opportunity for complete expression of feeling with the patient during his last days. We fail to realize that approaching death, and dying, may be just as much of a positive experience, and just as clear an expression of the capacities within the individual, as any other experiences in life.

After we have completed diagnostic studies we are in a position to make therapeutic recommendations. It is part of the physician's responsibility to apply all the scientific knowledge and skill which he has available in treating the disability present, but at the same time he must recognize the emotional implications of his treatment and attempt to maintain an honest relationship with his patient. If there is a functional disturbance present, either as a primary disability, or secondary to the basic problem, it is the physician's responsibility to point out to the patient that he has an emotional disturbance.

In attempting therapy for an emotional disturbance, it is important that the physician recognize that his most important aim is that he establish a relationship which will enable the patient to find relief from anxiety, and an opportunity for emotional growth and development. The personality of the physician becomes a therapeutic factor in this relationship, and it is necessary that the physician respond to the patient with honesty, warmth, and sincerity. The physician's skill in recognizing minute details of emotional expression from the patient promotes a closer relationship with the patient,

in which he can give expression to the deep emotional strivings which he has not known how to express satisfactorily in other relationships. The doctor must realize that he does not always know what is best for his patient, and consequently he can only offer the patient the benefit of his own knowledge and experience. This implies that the basic direction for the therapeutic process arises out of the needs and expressions of the patient, and it is necessary for the physician to reflect the patient's attitudes back to him in such a manner that the patient can see them clearly and determine the course which he wants to follow. This is sometimes referred to as a nondirective technic in that the actual direction for therapy arises in the patient, but it is well recognized that the personal attitudes and philosophy of the physician will be a definite factor in directing the patient's productions. In many instances it is found to be a very worthwhile rule to keep quiet, and make no comment, unless you are absolutely sure that you understand what the patient is trying to say, and unless you are sure that you can provide some helpful comment. This means that the responsibility is thrown back upon the patient, and he is made to realize that his final salvation must come from within himself rather than from the physician.

It is well for physicians to recognize that their own strength of character and belief in themselves provides the steadying factor in this relationship, which is all important to the patient. The mere fact that the patient can express his anxiety to the physician, *without* arousing anxiety in the physician, is the real therapeutic experience. We always reflect our own anxiety and lack of personal security when we make an effort to correct our patient's thinking, or to tell them how to live their lives. This reflects a basic lack of respect for, and confidence in, the individual patient, and the patient is very sensitive in recognizing this lack of respect on the part of the physician.

I have endeavored to describe some of the important aspects of the doctor-patient relationship as these are seen by the psychiatrist. Present day psychiatry contributes a real body of scientific knowledge in defining the dynamic or etiological factors in mental illness, the psychoneuroses, and the so-called psychosomatic disturbances. This knowledge can prove very worthwhile to the medi-

cal practitioner in his day by day contacts with individual patients, but the knowledge will be valueless unless he is able to make an adequate emotional contact with his patient. These facts are not recognized in a routine medical investigation unless the physician is conscious of his patient's emotional attitudes and responses, and able to recognize the nature of these.

It is well recognized that we associate many feelings of disturbed emotions with our gastro-intestinal tract. We speak of being "hungry for love", the feeling of disgust which makes us "want to vomit", and all of the hostile expressions which we refer to the excretory functions. The patient with peptic ulcer is found to have strong dependent needs, which he fails to express except through his sickness. The patient with chronic diarrhea, or mucus colitis, is frequently found to have a typical pattern characterized by the feeling of obligation or over-conscientiousness, or at times intense hostility. The case of chronic constipation frequently is recognized as being chronically depressed and withholding all emotional responses.

The influence of emotions upon the respiratory functions is well known from every day experiences. We speak of experiences as "breath-taking", or "it took my breath away". Sighing and crying are recognized as common means of emotional expression. In most cases of bronchial asthma there is some evidence of an emotional factor playing a part in the precipitation of attacks. The conflict most frequently found in asthma is an excessive dependence upon the mother, or mother figure, which is repressed, and finds expression in the restriction of expiratory efforts. This is sometimes spoken of as the "choked off cry for the mother's breast."

The relationship of emotional disturbances to heart disease and hypertension are well recognized by those individuals specializing in this field. The close correlation of anxiety and rage with heart action is well known, and repressed hostile impulses are frequently found to be important factors in cardiac disturbances and hypertension.

The psychogenic headache has been a headache to the practitioner throughout history, and we find that the only worthwhile treatment for many of these recurrent headaches is psychotherapy.

The dermatologist recognizes many skin

disturbances which are a result of emotional factors, and we are all familiar with the normal changes in the skin, such as blushing, pallor, increased perspiration, and the pylomotor response with hair standing on end, which we see in normal individuals.

The effect of emotions on the musculo-skeletal system is not definitely worked out at the present time, but it is obvious that any type of anxiety is associated with tension in the skeletal muscles and there seems to be a definite relationship between repressed hostility and the development of arthritic symptoms in some cases.

In addition to these contributions to our understanding of the etiology of disease, we are also making contributions to therapy. I have called attention to the important aspects of the doctor-patient relationship in therapy. I also wish to mention the fact that we are using certain specialized technics, such as group psychotherapy, psycho-drama, hypnotherapy, and other technics which are directed toward helping the patient to obtain a more adequate level of emotional functioning and maturity. We have also developed certain technics in the field of physical therapy, such as electric shock, electric sleep, insulin shock and surgical operations upon the frontal lobes of the brain. All of these technics are directed toward the relief of anxiety in the patient. It is necessary to follow these with psychotherapy in order to effect a process of emotional growth and development within the individual.

In summary, I wish to point out that the developments in present day psychiatry make it necessary that all of us engaged in the practice of medicine should examine ourselves closely in our relationships with our patients and our attitudes toward our patients as individuals. Psychiatry is calling attention to the necessity for mature attitudes in all of our professional relationships, and I am sure that it is the sincere desire of every practitioner of medicine that he be able to incorporate this skill and understanding into his own professional capacity. It is an ideal that all physicians be so adequate in inter-personal relationships that there will be no further need for specialists trained in this field alone. It is my hope that this ideal may stimulate more adequate teaching methods in our medical schools, and better opportunities for sharing therapeutic experiences at our postgraduate meetings.

THE TREATMENT OF RHEUMATIC FEVER AND ITS COMPLICATIONS

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Lecture notes taken by Dr. Redfearn during course given by
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Rheumatic fever was known to the ancients and unfortunately the study of this disease had a bad start because it was always considered primarily to be a disease of the joints. A better understanding of the histopathology of the disease shows that all tissues may be involved but primarily the small blood vessels. The disease, therefore, is universal in its attack upon the tissues of the body and during the latter years of life it has been found to attack all peoples irrespective of race, creed, color, age and geographic location.

It does not spread like an infection and is said to be more prevalent in warm climates. The hemolytic streptococcus is suspected of being an important contributing agent. The reported low incidence in warm climates may in part be explained on the basis of variability of the symptoms of the disease that prevails in different climates. It has a seasonal variation and it is said to be three times as prevalent in the winter than in the summer. Poverty, heredity, crowding and dampness seem to be contributing factors. It is well-known that if both parents had rheumatic fever, all the offsprings would be susceptible, but it is not clearly known as to whether this disease follows accurately the Mendelian law of heredity. It is felt by some observers that it probably is transmitted along as a recessive gene.

It is suspected that Hippocrates, almost 4000 years ago, knew the symptoms of rheumatic fever. However, it was not until the last century that the relationship between rheumatic fever and rheumatic heart disease has been established. The specific nature of rheumatic fever has been described by Aschoff in 1904 when he described the rheumatic nodule.

Endocarditis: It is now the feeling of most students of rheumatic fever that the involvement of the valves is a late manifestation. It is well-known that the mitral valves are affected in all cases of rheumatic fever; the aortic valves in 50 per cent of cases; tricuspid valves in 35 per cent; and the pulmonary valves only rarely. Autopsy material shows that in active rheumatic fever two-thirds of all cases have disease in the conduction system; one in every five have involvement in the aorta. The coronary vessels are involved in 15 per cent of active material.

Manifestations: Growing pains have been explained on the basis of the occurrence of multiple microscopic fractures produced during play. When the extremities are at rest these microscopic fractures are filled up with blood, producing pres-

sure and, therefore pain. This type of pain, which is not rheumatic, may be relieved, in many ways by the application of heat or cold, massages, psychologic means. True rheumatic pains cannot be relieved in this manner.

The most common single manifestation of rheumatic fever in children is abdominal pain. The rigid abdomen with para-umbilical pain associated with laboratory and clinical symptoms, which may be easily mistaken for appendicitis, may occur in children with rheumatic fever. This is explained on the basis of rheumatic peritonitis. Many children develop acute hepatitis of a rheumatic origin. Kidney involvement simulates that of glomerular nephritis, and generalized lymphadenopathy may occur in rheumatic fever.

Classification of Manifestations: In order to understand the clinical picture of the natural history of rheumatic fever, it is found feasible to classify the manifestations into four classifications: (1) latent, (2) acute, (3) protracted, (4) quiescent. Each one of these periods in the illness has its own symptoms. The latent or pre-rheumatic phase begins early in life. The first symptoms during this phase may be personality pattern changes. Fatigability, progressive pallor, and frequent abdominal pain may be the only manifestations of rheumatic fever at this period. The acute, exudative or explosive stage begins at about school age. The predominant characteristic is the presence of protracted carditis with progressive heart disease. During this phase of the disease, clinical polyarthritis and pancarditis are often observed. Then comes the protracted proliferative phase during which the patient loses all the exudative phenomena and shows the signs of progressive endo- and myocarditis. Following this stage the patient who recovers enters the so-called quiescent phase or subclinically active phase. During this period of the disease, the patient does not demonstrate any of the symptoms of rheumatic fever and may indeed be symptom-free for many years. It is during this phase of the disease that the patient causes himself little harm by physical activity, although he may have considerable residual cardiac damage.

Diagnosis: The study of murmurs is of secondary importance in rheumatic fever in children, from the standpoint of the evaluation of the cardiac status. However, we study cardiac sounds and murmurs from force of habit. The short "P-R" interval in the electrocardiogram, for example, is associated with a loud first heart sound,

the prolonged "P-R" interval, with a low first sound; the "weak" first heart sound, therefore, may be of very little clinical significance. Murmurs, for practical purposes, may be classified according to their loudness and pitch. The grading of murmurs, as proposed by Levine, is now widely accepted as a workable scheme for recording and describing murmurs. It is now felt that most murmurs have "organic" significance. It is felt that if there is a history of rheumatic fever, even a grade I murmur may be significant of rheumatic heart disease. A grade III murmur is always organic. Grade IV is a type of organic murmur that never disappears. It must be said, however, that the prognosis cannot be made on the basis of murmurs in rheumatic fever. The degree of carditis is more significant than the number and location and type of murmurs heard.

Of greater significance from the standpoint of prognosis is the size of the heart. Therefore, it is of utmost importance to develop some technic for measuring small differences in the size of the heart. One cannot afford to be misled by the apparent change in the size of the heart in deep inspiration and expiration. Therefore, the cardiothoracic ratio is not reliable in children. The esophogram, or the study of the barium-filled esophagus, is a valuable addition in the measuring of the size of the heart. This method is simple and may be carried out by fluoroscopy. The angle of clearance, or that angle at which the left ventricle clears the spine in the left anterior position, is another valuable method for measuring the size of the left ventricle. The bifurcation of the two bronchi gives another indication of the size of the left auricle. Thus, studying the anatomic relationship of the heart to the esophagus, to the bifurcation of the bronchi, and to the spine, gives a good deal of information regarding the change in the size of the various cardiac chambers.

The electrocardiogram has always been considered of questionable value in the diagnosis of acute rheumatic fever. In recent years there has been a return to the measurement of the electrical events of the cardiac cycle. The measurement of the "Q-T" interval in acute rheumatic heart disease, as proposed by Taran and Sizlagyi, dispels a good deal of confusion and outlines clearly the value of this measurement in the diagnosis of acute heart disease. For several years they carried out detailed clinical and electrocardiographic studies on several hundred rheumatic children during the acute and quiescent phases of the disease. They teach that great care must be exercised in measuring the "Q-T" interval. Physiologic and pharmacologic factors in addition to overt disease of the myocardium may influence this relationship for they may lengthen or shorten the "Q-T" interval.

Hyperpotassemia, digitalis, salicylates and pericarditis of any etiology shorten the "QTc". Exercise, excitement, fever, hypopotassemia, hypocalcemia, quinidine, carditis of any cause, myo-

cardial infarction, hypertension, abnormal widening of "QRS" and coma lengthen the "QTc". Some E.K.G. tracings must be thrown out because of the difficulty in finding the end of the T-waves and differentiating between the "T" and "U" waves. The gross arrhythmias are also left out. At least six cardiac cycles and six Q-T intervals are measured in order to get the average. Often it is necessary to measure twelve cycles in each of six leads to maintain a high degree of stability. Their upper limit of normal "QTc" is .405 seconds. Their method of measuring and calculating the corrected "Q-T" interval (QTc) is:

$$K (QTc) = \frac{Q-T \text{ (average of 6 inch strip of cycles in each of 6 leads)}}{\sqrt{R-R \text{ (average of same cycles.)}}}$$

By slide rule to get QTc, multiply average of 6 leads x .04 seconds. To get cycle length multiply average cycle length x .04.

1. Scale (A) hairline is placed on number representing cycle length in seconds.
2. Scale (C) is moved until the number representing Q-T in seconds is directly under hairline.
3. Hairline is moved to number (1) on Scale (A).
4. On scale (C) number directly under hairline is read off. This number is corrected "QTc".

Treatment: From time to time over the past century, many forms of treatment have been used in rheumatic fever, and rheumatic heart disease. Each form had its heyday and was then considered as specific. Various vitamins, vaccines from the hemolytic streptococcus, and various forms of salicylates have been used. The results from any of these did not add materially to the total management of this disease. For some time, the matter of removal of foci of infection was considered an important addition to the management of this disease, particularly the removal of tonsils and adenoids. At another time, the removal of a patient to a warm, dry climate was considered as specific therapy. It must be admitted that none of these forms of treatment materially benefited the patient.

It is now felt that much can be done for the child with rheumatic fever if we consider his disease as having various phases, with each phase requiring its own form of treatment. During the pre-rheumatic stage, it is well to protect the child against repeated infections and against trauma of any sort, physical or emotional. During the exudative phase, salicylates in massive doses stood the test of time and can still be used with great effectiveness. It is during this phase of the illness that Cortisone and ACTH can be used with as effective results as massive doses of salicylates. It must be remembered, however, that these hormones cannot be used indiscriminately, and their use in disease, in general, and in rheumatic fever

in particular, is still in the experimental stage. Much remains to be learned about the dosage and the method of administration; furthermore, much remains to be learned about the untoward effects, which may accrue with the use of these hormones over a long period of time. For the moment, Cortisone and ACTH can be considered as super salicylates in the treatment of the exudative phase of rheumatic fever. Similarly, it is important to remember that salicylates may sometimes produce severe intoxication. This, when recognized, requires immediate stopping of the drug and active anti-salicylism treatment.

Once the exudative phase of rheumatic fever has passed, and the patient has settled down to the protracted phase of carditis, adequate management becomes difficult. It has been the experience at the St. Francis Sanatorium that oxygen therapy during this phase of the illness, provided the patient does not demonstrate obvious evidence of congestive failure, does much to prevent progressive cardiac damage. Here, it is given in concentrations of 50 per cent. The child is placed in a chamber which does not have the earmarks of an oxygen tent with all its psychological fears and anxieties. Here children may be kept for a matter of weeks and sometimes months. It is interesting to note that this form of therapy with all its elaborateness is, in the long run, less expensive than the usual oxygen therapy employed in the average hospitals. It is suggested by this form of therapy, that if hospitals would build oxygen rooms for patients with acute heart disease they would eventually save money in the use of oxygen therapy in heart disease.

The stage of congestive failure in rheumatic heart disease is a difficult problem for the cardiologist. The nature and mechanism of congestive failure in acute rheumatic disease is apparently somewhat different than the mechanism in congestive heart disease in the failure of the arteriosclerotic heart. For that reason, the use of digitalis must be looked upon with much more concern. Since it does not always produce the favorable results seen in arteriosclerotic heart disease. In this group of cases, the judicious use of mecurials has almost displaced the use of digitalis. Thus, patients can be kept dry on a maintenance dose of mecurials for many months.

Once the patient has reached the so-called irreversible stage, the stage at which he has complete heart failure, and in addition, recrudescence of the exudative process of rheumatic fever, none

of the usually employed therapeutic measures are of any avail. However, even in this group, one in every ten patients may be saved, according to the evidence accumulated at the Sanatorium by the use of concentrated Dextrose, covered by adequate doses of insulin given daily, while the patient is in a 50 per cent oxygen atmosphere.

Summary and Conclusions: Many years experience with a large number of rheumatic children at St. Francis Sanatorium teaches many lessons regarding the nature of this ill-understood disease. Careful follow-up of this group of patients over a long period of time, gives clear indication that although rheumatic fever was known for many centuries, it was not suspected that the disease is of months' or perhaps years' duration. While the pathologic histology was described by Aschoff at the beginning of this century, the clinical relationship between this disease and heart disease has been known to Jenner, Bouillard and others, the true natural history of this disease has only recently begun to be understood. It is clear from the experience at this Institution, that:

1. Rheumatic fever begins in early life.
2. It is a disease which may last for many months or years. It is possible that it does not become quiescent in the pathologic sense.
3. From the diagnostic standpoint, the most valuable additions to the diagnostic armamentarium, is a careful study of the patient's heart, since rheumatic fever is always a disease of the heart. In this respect, valvular damage is of secondary consideration; carditis of primary. Since the heart muscle is always involved, a study of the function of the heart is bound to lead to fruitful conclusions regarding the presence or absence of mild rheumatic carditis. From this point of view, an important contribution has been made in the St. Francis Sanatorium, where a thorough study of the electrical events of the cardiac cycle has been made, and this shows that certain measurements may signify active impairment of the myocardial function, even in mild rheumatic carditis. The prolongation of the "QTc" on the electrocardiogram is here considered a sensitive index, not only of the presence of acute carditis but also of its severity.
4. From the standpoint of treatment the experience at this Sanatorium has added much valuable information. It has been shown that when each specific phase of the illness is treated in its own manner, the outlook for the patient is better than it was heretofore.

PUBLIC HEALTH

A thousand-page volume entitled *History of the United States Public Health Service*, written by Dr. Ralph Chester Williams, director of hospital services, Georgia Department of Public Health, has just been published. The book, the writing of which required 25 years, tells of the development of the USPHS, its work during the wars, and the

fight against plague, yellow fever, typhoid and malaria.

Dr. Williams, a native of Alabama, was a member of the corps of the U. S. Public Health Service for 37 years, and at the time of his recent retirement was assistant surgeon-general. He then joined the staff of the Georgia Department of Public Health, Atlanta.

Organization

CONSTITUTION AND BY-LAWS

Adopted at the 101st Annual Session of The Medical Association of Georgia, Augusta, Georgia, April 17-20, 1951.

CONSTITUTION

ARTICLE I.

NAME OF THE ASSOCIATION

The name of this organization is The Medical Association of Georgia.

ARTICLE II.

PURPOSES OF THE ASSOCIATION

The purposes of the Association shall be to advance the science of medicine; to promote the interests and uphold the honor of the profession of medicine; to acquire, utilize and disseminate information relative to all diseases and degenerative processes affecting mankind to the end that the people of Georgia may have the most adequate medical care possible; to promote public health, and to foster cordial relations between the members of the medical profession and the general public.

ARTICLE III.

COMPONENT SOCIETIES

Component societies are those county medical societies which hold charters from the Association or which may hereafter be organized and chartered by the House of Delegates of the Association.

ARTICLE IV.

COMPOSITION OF THE ASSOCIATION

SECTION 1. The Association is composed of members and delegates.

SEC. 2. MEMBERS. The members of the Association are the members of the component county medical societies.

SEC. 3. DELEGATES. Delegates are those members elected in accordance with this Constitution and By-Laws to represent their component county medical societies in the House of Delegates of the Association.

ARTICLE V.

HOUSE OF DELEGATES

SECTION 1. POWERS. The legislative body of the Association is the House of Delegates and it shall transact all business of the Association not other-

wise specifically provided for in this Constitution and By-Laws.

SEC. 2. COMPOSITION. The House of Delegates is composed of (1) delegates elected by the component county medical societies, (2) the officers and past presidents of the Association and (3) the delegates to the American Medical Association.

ARTICLE VI.

COUNCIL

SECTION 1. The Council shall be the Board of Trustees and the Board of Censors of the Association. It shall carry out the mandates and policies as determined by the House of Delegates. The Council shall have full authority and power of the House of Delegates between sessions of that body. The Council shall have charge of all the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

SEC. 2. The Council shall consist of the President, the President-Elect, the Secretary-Treasurer and one Councilor from each Congressional District in the State of Georgia.

ARTICLE VII.

SESSIONS AND MEETINGS

SECTION 1. ANNUAL SESSION. The Association shall hold an annual session during which there shall be general meetings open to all registered members, delegates and guests.

SEC. 2. TIME AND PLACE. The time and place for holding each annual session shall be fixed by the Council.

SEC. 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-third vote of the Council, twenty delegates or upon written petition of one fourth of the members of the Association.

ARTICLE VIII.

DISTRICT SOCIETIES

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts, which shall be coextensive with the Congressional

Districts in Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies.

ARTICLE IX.

OFFICERS

SECTION 1. OFFICERS. The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor from each of the Councilor District Societies as provided in the By-Laws. All elections shall be held as prescribed in the By-Laws.

SEC. 2. ELECTION AND ELIGIBILITY. The officers of the Association shall be elected by the members during the annual session. No person shall be eligible to an elective office who has not been a member of the Association for the preceding three years.

SEC. 3. TERMS OF OFFICERS. The President-Elect shall be elected annually. He shall become President on his installation at the close of the next annual session. If the President-Elect be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session. Other officers shall be elected for terms of one year each, except the Secretary-Treasurer and the Councilors who shall serve for three years. One third of the Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

ARTICLE X.

FUNDS AND EXPENSES

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component county medical society. The amount of the assessment shall be set annually by the House of Delegates upon the recommendation of the Council. Funds may also be raised by voluntary contributions, from the Association's publications and in any other manner approved by the House of Delegates.

The Council shall submit an annual budget to the House of Delegates. The Council shall manage the finances of the Association and shall supervise all funds, investments and expenditures of the Association. All resolutions providing for appropriations, recommended by Council, shall be included in the annual budget, subject to final approval by the House of Delegates.

ARTICLE XI.

OFFICIAL PUBLICATION

The official publication of the Association shall be THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, in which shall be published all official Association notices, abstracts of transactions of the House of Delegates and general meetings of the Association, the annual budget and abstracts of meetings of the Council.

ARTICLE XII.

SEAL

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII.

AMENDMENTS

The House of Delegates may amend this Constitution by a two-thirds vote of the Delegates present at any annual session, provided that such amendment shall have been presented to the House of Delegates at the previous annual session and that it shall have been published during the year in THE JOURNAL of the Association, or sent officially to each component county society at least two months before the annual session at which final action is to be taken.

BY-LAWS

CHAPTER I.

MEMBERSHIP

SECTION 1. Any physician holding the degree of Doctor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been adjudged guilty of moral turpitude or other serious crime, may be eligible for membership in a component society of the Association.

SEC. 2. The name of a physician recorded on the official roster of a component county society, who has paid the annual dues and assessments of the component county society and of the Association, shall be *prima facie* evidence of membership in the Association.

SEC. 3. Membership in the Association shall be classified as active, associate, honorary and life.

SEC. 4. ACTIVE MEMBERS. All members shall be active, including the right to vote and hold office, unless otherwise classified by action of the component county society.

SEC. 5. ASSOCIATE MEMBERS. Any physician who is not engaged in the regular practice of medicine for any one of the following reasons, namely: (1) during organized periods of hospital training and graduate education, (2) during periods of service in the Armed Forces, (3) after retirement or (4) for whom the payment of dues would constitute a hardship, may be classified by the component county society as an associate member. Associate members shall be entitled to all the rights and privileges of the Association except that they shall not pay dues, receive THE JOURNAL or be eligible for Medical Defense.

SEC. 6 HONORARY MEMBERS. Eminent physicians and other persons who have distinguished themselves in the science of medicine, or for contributions to human welfare, may be elected to Honorary Membership in the Association by the House of Delegates upon nomination by any component county society. Such Honorary Members may be issued an appropriate certificate of membership without payment of dues.

SEC. 7 LIFE MEMBERS. A life membership may be granted by the House of Delegates, upon the recommendation of the component county society, to any physician who has had not less than forty years of active membership in the Association. He is not subject to payment of dues.

SEC. 8. A physician who is under sentence of expulsion from a component county society, or whose name has been dropped from its roll of members, shall not be entitled to any of the rights, privileges or benefits of the Association, nor shall he be permitted to take part in any of its proceedings.

SEC. 9. The cause of the failure of a practicing physician to affiliate himself with an available component county society, at any time, shall be ascertained before election to membership.

SEC. 10. Eligible physician members of the State and Federal medical services and full time members of approved medical faculties shall pay half the annual dues of the Association provided similar action has been taken by the component county society.

CHAPTER II.

GENERAL MEETINGS.

SECTION 1. The general meetings shall be open to all members and guests who have complied with the registration requirements. These meetings shall be presided over by the President or a Vice-President.

SEC. 2. The program for the general meetings shall be prepared by the Committee on Scientific Work and approved by the executive committee of the Council at least 60 days before the Annual Session of the Association and published in the issue of THE JOURNAL preceding the Annual Session.

SEC. 3. All papers read before the meetings shall become the property of the Association, and shall be deposited with the Secretary-Treasurer immediately after being read. Failure to comply with this and other rules set forth by the Committee on Scientific Work regarding papers, discussions and exhibits shall automatically bar scheduled participation in the scientific sessions in the future from this member for a period not less than five years unless he presents an acceptable excuse.

SEC. 4. Upon invitation of the President any physician may register at a general meeting of the Association as a guest upon presentation of ade-

quate evidence of membership in good standing in a component unit of the American Medical Association.

Distinguished lay persons and physicians may be invited as special guests of the Association by the President or by action of the Council. Privileges of the floor may be extended to guests at the discretion of the presiding officer.

CHAPTER III.

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet on the first and last day of the annual session at a time fixed by the Council and at such other times as may be necessary for the transaction of the business of the Association.

SEC. 2. Each component county society shall elect one delegate and a corresponding alternate for each fifty members, or fraction thereof, whose dues have been paid by March 1st of each year, provided that each component county society shall be entitled to at least one delegate. It shall be the duty of the President to have the representation of each component county society checked by the Committee on Credentials at the time of the annual session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy.

SEC. 3. Thirty of the registered members of the House of Delegates shall constitute a quorum. All sessions of the House of Delegates shall be open to the members of the Association, except when in Executive Session.

SEC. 4. The House of Delegates shall be presided over by the President and in his absence, by a Vice-President or by a delegate agreeable to it.

SEC. 5. The Secretary-Treasurer of the Association shall be the Secretary of the House of Delegates or, in his absence, by a delegate appointed by the President.

SEC. 6. The following shall be the general Order of Business at all meetings of the House of Delegates:

1. Call to order by the President
2. Roll Call
3. Reading and adoption of minutes
4. Reports of officers
5. Reports of committees
6. Unfinished business
7. New business

This order of business may be changed at any time by a majority vote of the House of Delegates.

SEC. 7. For the purpose of expediting proceedings the President shall appoint from the members of the House of Delegates, the following Reference Committees:

1. Committee on Credentials
2. Committee on Reports of Officers

3. Committee on Scientific Work
4. Committee on Public Policy and Legislation
5. Committee on Economics
6. Committee on Miscellaneous Business

and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in the debate, but shall not have the right to vote.

SEC. 8. All reports and resolutions shall be referred to the appropriate Reference Committees before action is taken by the House of Delegates.

SEC. 9. The House of Delegates shall nominate members of all Boards required by the Laws of Georgia.

CHAPTER IV.

COUNCIL

SECTION 1. The Council shall meet on the last day of the annual session of the Association to organize and at intervals of not more than four months apart until the next annual session. Special meetings of the Council may be held on the call of the President or upon request of three members of the Council.

SEC. 2. The Council shall be composed of the President, the President-Elect, the Secretary-Treasurer and one Councilor from each Councilor district. Each Councilor and Vice-Councilor shall be nominated by each district society at the time of its annual meeting. In the event of a vacancy in the office of a Councilor and Vice-Councilor, the vacancy may be filled temporarily by appointment by the President from members of that district society.

SEC. 3. The Council shall set up an Executive Committee, composed of the President, the Secretary-Treasurer, and two members. It shall meet not less often than bi-monthly to review the affairs of the Association. This committee shall make recommendations to the Council and shall carry out such items of business as are referred to it by the Council.

SEC. 4. The Chairman of the Council shall be elected annually at the organization meeting and shall serve one year, or until his successor is elected. He shall preside over its meetings and appoint all necessary committees. A Vice-Chairman shall be elected from among its members. The Secretary-Treasurer of the Association shall be the Secretary of the Council.

SEC. 5. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws.

SEC. 6. The Council shall be the Board of Censors of the Association. It shall consider all ques-

tions involving the right and standing of members, whether in relation to other members, to the component societies or to the Association. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

SEC. 7. Each Councilor shall be organizer, peace-maker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in, the betterment of the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties, and whenever practicable, shall attend meetings of the Council, but shall not have a vote except in the absence of his Councilor.

SEC. 8. Charters for county and district societies shall be issued on approval of the Council and shall be signed by the President and Secretary-Treasurer of the Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 9. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all the rights and privileges provided for component societies until such counties shall be organized separately. A physician residing in a county not having a component society, shall be referred to the nearest component county society by the Council for consideration for membership. Choice of any other component county society by such a physician for membership shall be made only with the full consent of all component societies involved.

SEC. 10. The Council shall provide for and superintend the issuance of all necessary publications of the Association, including proceedings, transactions and memoirs.

SEC. 11. The Chairman of the Council shall appoint from among its members, a committee of three members to be known as the Committee on

Auditing and Appropriations, which shall cause to be audited all accounts of the Association. The Council shall adopt an annual budget providing for the necessary expenses of the Association, which shall be prepared and presented for its consideration by the Committee on Auditing and Appropriations at the first meeting of the Council in the first quarter of each year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

SEC. 12. The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the annual session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it for the good of the Association without restriction, except properly to account in writing for its distribution to the House of Delegates.

SEC. 13. The Council shall appoint, at least six months before the annual session, a committee, consisting of three or more of its members, to be known as the Committee on Arrangements for the annual session. This committee shall appoint a general chairman of a local committee on arrangements, who shall be a member of the component society in which the annual session is to be held. This local Chairman shall appoint, from the members of his county society, the personnel of the local committee on arrangements. The local committee on arrangements shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements for the annual session. All expenditures made by that committee in connection with the annual session must be authorized in advance by the Committee on Auditing and Appropriations of the Council. Immediately after the annual session the Committee on Arrangements of the Council shall forward to the Secretary-Treasurer any accumulated balance. Any deficit created on account of the annual session shall be met by the Council on recommendation of the Committee on Auditing and Appropriations.

SEC. 14. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between annual sessions of the Association. The appointee shall serve until his successor has been elected and installed.

SEC. 15. The Council may appoint an Assistant Secretary-Treasurer or an Executive Secretary—either or both and fix their terms of employment.

SEC. 16. The Council shall determine the employment and salaries of all personnel necessary to con-

duct the affairs of the Association subject to approval of the House of Delegates.

SEC. 17. The Council shall provide such headquarters for the Association as may be required to conduct its affairs.

SEC. 18. The Council shall have control of all technical exhibits at the annual sessions.

SEC. 19. The Council shall fix the bond of the Secretary-Treasurer and all other necessary personnel of the Association.

SEC. 20. The Council shall have full and complete charge of all public relations of the Association, subject only to the House of Delegates.

CHAPTER V.

ELECTION OF OFFICERS

SECTION 1. The President-Elect, Vice-Presidents, Secretary-Treasurer, and Councilors shall be elected by ballot by the members of the Association. Nominations for these offices except Councilors shall be made orally as the first order of business at the beginning of the afternoon meeting on the first day of the scientific session, before the presentation of any papers. No nominating or seconding speech shall exceed two minutes. The President shall appoint a Committee of Tellers immediately after the close of nominations.

SEC. 2. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations for Councilor and Vice-Councilor from such district shall be made from the floor. One third of the Councilors and Vice-Councilors shall be elected annually.

SEC. 3. The Secretary-Treasurer shall have prepared in advance an official ballot. One ballot shall be given to each active voting member when requested. Such member and no other, shall prepare his ballot and shall deposit it in a locked ballot box provided by the Secretary-Treasurer and kept in his custody or that of the Tellers designated by the President. The key shall be kept by the Secretary-Treasurer of the Association or Chairman of the Tellers.

SEC. 4. Voting shall take place during the hours of the scientific program up to 10:30 A. M. of the last day of the annual session. At that time the Committee of Tellers appointed by the President shall count the ballots and report their findings to the members at the last meeting of the Association. The candidate for President-Elect receiving a majority of the votes shall be declared elected. Other officers shall be elected by receiving the highest number of votes on the first ballot.

SEC. 5. Delegates and Alternates to the American Medical Association shall be elected in the same

manner and at the same time and in accordance with the Constitution and By-Laws of the American Medical Association.

CHAPTER VI.

DUTIES OF OFFICERS

SECTION 1. THE PRESIDENT. The President shall preside at all meetings of the House of Delegates and of the Association and shall appoint all committees not otherwise provided for. He shall deliver an address at such time during the annual session as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and so far as practicable, shall visit by appointment, the various district societies, and shall assist the Councilors in building up the county societies, and in increasing the prestige of the Association. He shall be a member of the Council and its Executive Committee, and shall be a member of all committees of the Association with the authority to call a meeting of any Committee when necessity demands it or after failure of the chairman to do so. With the consent of the Council he shall terminate any committee whose function has been fulfilled. It shall be his duty with the approval of the Council, to replace any member of any committee who fails to attend forty per cent of the meetings of the committee, or in other ways fails to show interest in performing the duties assigned to him.

SEC. 2. THE PRESIDENT-ELECT. The President-Elect shall be a member of the Council, and shall be a member ex-officio of all standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and the Standing Committees.

SEC. 3. THE VICE-PRESIDENTS. The Vice-Presidents shall assist the President in the discharge of his duties. Upon request of the President, the Vice-Presidents will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice-Presidents, in their order shall succeed him for the unexpired term.

SEC. 4. THE SECRETARY-TREASURER. (a) The Secretary-Treasurer shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and its Executive Committee.

SEC. 4. (b) He shall be custodian of all record books and papers belonging to the Association and shall keep account of all funds of the Association which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation

of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall supply all component societies with the necessary blanks for making their annual reports, and shall collect the regular per capita assessments from the component societies. The amount of his salary shall be fixed by the Council.

SEC. 4. (c) He shall give bond in the amount of a sum to be fixed by the Council. He shall receive all funds of the Association, together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at the last meeting of the fiscal year at the annual session of the Association. This shall consist of an itemized statement of all financial transactions of the past year, all accounts made, money received and disbursed, with vouchers attached. The fiscal year includes the period of time between April 1st and March 31st

CHAPTER VII.

COMPONENT COUNTY SOCIETIES AND DISTRICT SOCIETIES

SECTION 1. COUNTY AND DISTRICT SOCIETIES. All county and district societies now in affiliation with The Medical Association of Georgia or those hereafter organized in this state, which have adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. CHARTER. Upon application to and recommendation by the Council, the House of Delegates shall provide and issue charters to county and district medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary-Treasurer. The House of Delegates shall have authority to revoke the charter of any component county society or district society whose actions are in conflict with this Constitution and By-Laws. Only one component county society shall be chartered in each county.

SEC. 3. NAMES OF SOCIETIES. The name and title of each component county society and district society shall read exactly as found in its charter. No change in such name shall be made without the

approval of the Council of The Medical Association of Georgia.

SEC. 4. CUSTODY OF CHARTER. The charter of each component county society and district society as issued by The Medical Association of Georgia, shall be preserved and shall be in the custody of the secretary of such society at all times.

SEC. 5. CONSTITUTIONS AND BY-LAWS. Each component county society and district society shall have a constitution and by-laws. These shall be in conformity with the Constitution and By-Laws of The Medical Association of Georgia, and a copy thereof shall be transmitted to the headquarters of The Medical Association of Georgia for approval and record.

SEC. 6. PURPOSES AND DUTIES. Each component county society shall have general direction of the affairs of the profession in the county and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 7. OFFICIAL RECORDS. The official copy of the constitution and by-laws of each component county society shall be kept in a special book provided for that purpose. In it shall be entered all amendments which have been ratified by the Council of The Medical Association of Georgia. It shall contain the signature of each member who is entitled to membership in The Medical Association of Georgia, together with the date of his election, decrease, resignation or expulsion. It shall be the duty of the secretary to preserve this book and hold it available when required for reference.

SEC. 8. DELEGATES AND ALTERNATES. Each component county society at its annual meeting shall elect delegates and alternates to represent it in the House of Delegates of the Association in accordance with these By-Laws, unless other definite procedure for the selection of delegates is provided in its constitution and by-laws. The secretary of each component county society shall send a list of such delegates to the Secretary-Treasurer of the Association at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with these provisions. In the absence of, or the disability or disqualification of a delegate, the vacancy shall be filled by the President from other members of the same component county society.

SEC. 9. COMBINED COUNTIES. The House of Delegates shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district or other classes of societies. Such societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for component county societies.

SEC. 10. ANNUAL MEETING. Each component county society shall designate the meeting held nearest to January 1st of each year as its annual meeting, at which time delegates to the House of Delegates, and a local member of the sub-committee on Public Policy and Legislation and sub-committee on Public Health will be chosen, and their names forwarded promptly to the Secretary of the Association.

SEC. 11. PURPOSES AND DUTIES OF DISTRICT SOCIETIES. District Societies shall have two meetings during the year. A Councilor and a Vice-Councilor shall be nominated at the appropriate annual meeting and forwarded to the Secretary of the Association to be elected by the Association for terms of three years in a rotating manner with other district societies. At the same time each shall elect a member to the sub-committee on Public Policy and Legislation and Public Health of the Association.

CHAPTER VIII.

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the Secretary-Treasurer of the Association. Neither shall the Secretary-Treasurer of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.

SEC. 2. The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

SEC. 3. For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

SEC. 4. Any county society which fails to make the reports required before the annual session of the Association, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

CHAPTER IX

STANDING COMMITTEES

SECTION 1. The Standing Committees of the Association shall be as follows:

- (a) Committee on Scientific Work
- (b) Committee on Public Policy and Legislation
- (c) Committee on Medical Education and Hospitals
- (d) Committee on Medical Defense
- (e) Committee on Professional Conduct
- (f) Committee on History and Vital Statistics
- (g) Committee on Public Health

SEC. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. One member of each standing committee shall be appointed each year by the President to serve for three or more years as required by each committee and announced at the time of the final meeting of the Association each year. Provided that for the first year the President shall appoint three or more members as required, with one member to serve for the necessary graduated period of years to meet these requirements. Failure of a member to carry out the duties of his committee assignment during any year shall automatically cause his removal at the time of the annual session and the President, with the consent of the Council, shall appoint another member to fill his unexpired term.

SEC. 3. THE COMMITTEE ON SCIENTIFIC WORK. The Committee on Scientific Work shall be composed of five members: the President, the Secretary-Treasurer and three members appointed for terms of three years each. The senior appointed member shall serve as chairman. The duties of the Committee on Scientific Work shall be to prepare and publish the Scientific Program of the annual session, subject to the approval of Council. It shall also prepare and publish all rules and regulations governing the selection and presentation of papers, discussions and Scientific Exhibits before the general meetings and shall present them for publication in the Journal of the Association.

The presentation of Scientific Exhibits for the annual session shall be under the direction of this committee. For this purpose, the committee may set up a sub-committee of three or more members with representatives from the two medical schools of the State. The committee has the authority to make awards for the best scientific exhibits presented each year.

All lectureships of the Association shall be under the control of this committee, but special sub-committees may be established to advise the committee concerning the selection of proper speakers for each lectureship. These special lectures shall be given before the general meetings at a time selected by the Committee on Scientific Work.

SEC. 4. THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION. The duties of the Committee on Public Policy and Legislation shall be to represent the Association in securing and enforcing legislation in the interests of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local and national affairs. It shall further the education of the general public in health matters fostering a sane point of view about proper medical care.

Each component county society and district society shall designate one member at its annual meeting to serve with the Committee on Public Policy and Legislation in an active capacity. Vacancies in this special sub-committee shall be filled by the President. In addition, the Woman's Auxiliary shall be requested to form a similar committee with representatives from each component auxiliary.

SEC. 5. THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS. The Committee on Medical Education and Hospitals shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies wherever possible, and shall serve for the Council on Medical Education of the American Medical Association in this State. It shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this State, and shall, when indicated, confer with the State Department of Health, the Georgia State Hospital Association and all related organizations and make recommendations to the Association. All problems relating to the postgraduate study of medicine in this State shall be referred to this committee.

SEC. 6. THE COMMITTEE ON MEDICAL DEFENSE. The Committee on Medical Defense shall consist of five members, of whom the Chairman of the Council and the Secretary-Treasurer shall be members. The other members, one of whom shall be elected Chairman, shall be elected by the Council for terms of five years each. The duties of this committee shall be to investigate and defend all damage suits brought against the Medical Association of Georgia; to investigate all claims of alleged malpractice made against its members and to take full charge of such cases that are deemed to be worthy of defense; to defend all such cases in the courts of last resort, to furnish General Counsel and pay

court costs usual to such litigation, and reasonable fees for local attorneys as shall be arranged by Council. Any member who has indemnity insurance shall have such insurance bear its portion of the expense. However, they shall not pay, or obligate The Medical Association of Georgia to pay any judgment rendered against any member upon the final determination of any case. It shall be empowered to contract with such agents and attorneys as it may deem necessary for the proper carrying out of this By-Law. The assistance for defense, as herein provided, shall be available only to members of The Medical Association of Georgia in good standing.

Any member of the Association threatened with suit for alleged civil malpractice shall immediately communicate with the Secretary-Treasurer of the Association and shall give full and complete information in reference to all the circumstances alleged in the complaint. He shall immediately notify the Chairman of this committee who shall investigate the circumstances reported and shall advise with the attorneys or agents employed by the committee for this purpose. The member sued, or threatened with suit, shall be consulted and shall have the complete confidence of the committee in all transactions connected with the investigation in question. The committee shall have the authority to require of a constituent society or the president thereof, the appointment of a committee of investigation in any such case, and it may direct the committee so appointed to report to the Committee on Medical Defense and not to the society from which it was appointed.

The Committee on Medical Defense may assist in the prosecution of illegal practitioners in the State of Georgia and assist in the enforcement of the Medical Practice Act of this State.

SEC. 7. THE COMMITTEE ON PROFESSIONAL CONDUCT. The Committee on Professional Conduct shall consist of the five most recent past presidents of the Association. The senior member shall be Chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of The Medical Association of Georgia. All complaints or accusations against any member of The Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigation of a member, shall become the concern of this Committee. Complaints may be made by an individual patient, physician, board of censors of any local medical society, attorney, or any officer of a regularly constituted court of law. Upon receipt of notice of such complaint, the Committee, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if

the Committee is convinced that there is sufficient justification for a hearing the physician shall be requested to appear before at least three members of said Committee to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged only at such hearing. No member of this Committee shall sit in a hearing involving a physician from his Councilor District.

After deliberation, the Committee shall have a choice of one of the four following dispositions:

1. Dismiss the case because of insufficient grounds for a legitimate complaint.
2. Attempt a satisfactory adjudication of the complaint.
3. Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.
4. Refer to the Council of The Medical Association of Georgia all cases in which action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of The Medical Association of Georgia.

Nothing in this By-Law shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

SEC. 8. THE COMMITTEE ON HISTORY AND VITAL STATISTICS. It shall be the duty of the Committee on History and Vital Statistics to stimulate and promote the preparation of suitable articles on the history of the Association and its members, and shall recommend their publication to The Journal of the Association. It shall prepare memorials for deceased members, and arrange for their publication. It shall also report to the House of Delegates all new and eligible physicians who were licensed in the state during the past year indicating those who have become members of the Association. The Editor of The Journal and the President of the State Board of Medical Examiners shall be ex-officio members of this committee.

SEC. 9. THE COMMITTEE ON PUBLIC HEALTH. The Committee on Public Health shall be assisted by a sub-committee of one member elected by each county and district society of the state. Its duty shall be to advise with the Governor and other State officials, and with the Georgia State Board of Health and other related groups in regard to all matters concerning the health of the citizens of Georgia. It shall meet at the time of each session of the Georgia State Legislature with the Committee on Public Policy and Legislation to give assistance in carrying out its duties.

The Committee shall also have charge of all matters concerned with medical preparedness and

civilian defense in the event of war or other catastrophe. This work will be done in cooperation with national committees set up for the same purpose.

CHAPTER X.

SPECIAL COMMITTEES

Special committees may be created at any time when the necessity arrives. Their necessity must be approved by the Council and they shall be appointed by the President. The following are now authorized:

1. Woman's Auxiliary
2. Insurance and Economics

CHAPTER XI.

THE JOURNAL

SECTION 1. THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA herein referred to as THE JOURNAL, shall be under the control and direction of the Council. It shall appoint an Editor, and an Editorial Board and make any other provisions for the publication of THE JOURNAL which in its judgment are necessary. Such appointee or appointees shall serve at the pleasure of the Council, which shall have full discretionary power to promulgate rules and regulations governing the publication of THE JOURNAL; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SEC. 2. The Council may employ an Executive Secretary and Business Manager of THE JOURNAL and fix the terms of such employment.

SEC. 3. All papers presented before the annual session shall be submitted to the editor for consideration for publication in THE JOURNAL. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

CHAPTER XII.

RULES AND ETHICS

SECTION 1. The Principles of Ethics of the American Medical Association shall govern the members of this Association.

SEC. 2. The deliberations of the Association shall be conducted in accordance with parliamentary usage contained in the then current edition of Robert's "Rules of Order, Revised," unless contrary to this Constitution and By-Laws.

CHAPTER XIII.

AMENDMENTS

These By-Laws may be amended at any annual

session by a majority vote of the House of Delegates after the amendment has lain on the table for one day.

CHAPTER XIV

On the adoption of this Constitution and these By-Laws all rules and regulations in conflict herewith are hereby repealed, provided that all officers, delegates and committeemen now in office shall continue their incumbency until their successors are duly elected and installed or chosen as herein provided.

APPENDIX

STATE BOARD OF WORKMEN'S COMPENSATION OF GEORGIA

The provisions for a Medical Board, its appointment, tenure, compensation, expenses and functions are set forth in Section 114-822, Code of Georgia, as follows:

"There is hereby created and constituted a Medical Board to pass on controversial medical questions in claims for compensation growing out of death or disability on account of occupational diseases. Such Medical Board shall be appointed by the Governor in the following manner: As soon as practicable after the effective date of this Chapter, the Medical Association of Georgia, under procedure prescribed by it, shall nominate to the Governor the names of 10 physicians licensed and qualified to practice medicine in the State of Georgia, with particular reference to their training and experience in the fields of internal medicine, roentgenology, diseases of the chest, pathology, diseases of the skin and toxicology. The members of said Medical Board so nominated shall be appointed as nearly as is practicable from different geographical sections of the State. From said list so nominated for the organization of said Medical Board, the Governor shall select five physicians to compose said Board. One of said members shall be designated by the Governor to act as chairman. Such members of the Board shall be appointed for terms of one, two, three, four and five years, and thereafter, their successors shall be appointed for terms of two years each. The members of said Board shall meet at the call of the chairman at a place to be designated by him. The State Board of Workmen's Compensation shall be authorized to expend for the proper performance of the duties of said Medical Board such sums as may be deemed necessary in order to effectuate the purposes of said Board, and while actually engaged in the performance of their duties the members of that Board shall be paid their reasonable and necessary traveling expenses incurred in line of duty and a compensation to be fixed by the State Board of Workmen's Compensation on a scale not to exceed \$50 per day.

"The function of said Board shall be as set forth in this Chapter, and it shall be authorized to hear and determine controversial issues of medical facts arising from claims for compensation growing out of occupational diseases. As and when vacancies occur upon said Board by death, disability, resignation or expiration of term of office, the Medical Association of Georgia shall nominate to the Governor at least two physicians for each vacancy as herein set forth, and the Governor shall appoint from the list so furnished the member or members to fill the existing vacancy or vacancies.

"In the event that the said Medical Association of Georgia should fail and refuse after a reasonable time to nominate to the Governor the members of said Board as originally to be appointed for any vacancy (the Governor being the judge of what constitutes a reasonable time hereunder), the State Board of Workmen's Compensation shall have the authority to nominate to the Governor the members of said Board in the same manner as herein set forth for nomination by the Medical Association of Georgia. (Acts 1946, pp. 102, 114.)"

BOARD OF HEALTH OF THE STATE OF GEORGIA

The Board of Health of the State of Georgia is selected as provided in Sections 88-102 to 88-104 of the Georgia code, as follows:

"88-102, Georgia Code of 1933. State Board of Health members; number; appointment; qualifications; Governor as ex-officio member.—The Board of Health shall be composed of 14 members, appointed by the Governor and confirmed by the Senate, four from the State at large and one from each congressional district: Provided, that such appointments shall be made from lists of nominees submitted to the Governor by the governing bodies of the Medical Association of Georgia, the Georgia Dental Association, and the Georgia Pharmaceutical Association. The nominees submitted by the governing body of the Georgia Pharmaceutical Association shall be from the State at large, and shall be at least four in number, from which two appointments shall be made by the Governor. The nominees submitted by the Medical Association of Georgia shall be at least 20 in number, two from each congressional district, from which 10 appointments, one from each congressional district, shall be made by the Governor. A majority of all the members of the Board shall, at all times, be practicing physicians in the State. The Governor shall be ex-officio a member of said Board of Health. (Acts. 1933, pp. 7, 9.)

"88-103, Georgia Code 1933. Vacancies in Board; chairman and vice chairman.—In case of a vacancy, from any cause, in the membership

of the Board, the Governor shall fill the vacancy by appointment, to be confirmed by the next succeeding session of the Senate, from a list of at least two nominees submitted by the governing body of the organization named in section 88-102, whose nominee's place has become vacant. The Board of Health shall elect one of its members as chairman, and one as vice chairman. (Acts 1933, pp. 7, 10.)

"88-104, Georgia Code 1933. Terms of office of members of Board.—The terms of office of the 14 members first appointed shall be as follows: Two shall be appointed for a term ending September 1, 1934; two for a term ending September 1, 1935; two for a term ending September 1, 1936; two for a term ending September 1, 1937; three for a term ending September 1, 1938; three for a term ending September 1, 1939; and their successors shall be appointed for full terms of six years each. (Acts 1933, pp. 7, 9.)"

HONORARY ADVISORY BOARD

W. S. Goldsmith	President, 1915-1916
Eugene E. Murphey	President, 1917-1918
J. W. Palmer	President, 1918-1919
J. W. Daniel	President, 1923-1924
Frank K. Boland	President, 1925-1926
C. K. Sharp	President, 1928-1929
Wm. R. Dancy	President, 1929-1930
M. M. Head	President, 1932-1933
C. H. Richardson	President, 1933-1934
Clarence L. Ayers	President, 1934-1935
James E. Paullin (deceased)	President, 1935-1936
B. H. Minchew	President, 1936-1937
Grady N. Coker	President, 1938-1939
J. C. Patterson	President, 1940-1941
Allen H. Bunce	President, 1941-1942
James A. Redfearn	President, 1942-1943
W. A. Selman	President, 1943-1944
Cleveland Thompson	President, 1944-1946
Ralph H. Chaney	President, 1946-1947
Steve P. Kenyon	President, 1947-1948
Edgar H. Greene	President, 1948-1949
Enoch Callaway	President, 1949-1950
A. M. Phillips	President, 1950-1951

DUES FOR 1951

Medical Association of Georgia	\$15.00
American Medical Association	25.00

Payable to Secretary-Treasurer of your county society ONLY. Payments cannot be made direct to this office by members. (See new By-Laws, Chapter 8, Section 1, page 518 of this Journal).

ANNUAL SESSION

Atlanta	May 11, 12, 13, 14, 1952
Headquarters	Biltmore Hotel, Atlanta

Note: Program Committee meets in January. Submit titles now.

THE MEDICAL ASSOCIATION OF GEORGIA

875 West Peachtree Street, N. E.

ATLANTA, GEORGIA

OFFICERS FOR 1951-52

President—W. F. Reavis, Waycross
 President-Elect—C. F. Holton, Savannah
 First Vice President—Robert C. McGahee, Augusta
 Second Vice President—H. Ansley Seaman, Waycross
 Secretary-Treasurer—David Henry Poer, Atlanta
 Executive Secretary—Mr. Sid Wrightsman, Jr., Atlanta

DELEGATES TO THE A.M.A.

Terms expire December 31, 1952:

B. H. Minchew, Waycross, and Eustace A. Allen, Atlanta. Alternates: William R. Dancy, Savannah, and Carter Smith, Atlanta.

Terms expire December 31, 1953:

C. H. Richardson, Sr., Macon. Alternate, C. L. Ayers, Toccoa.

EXECUTIVE COMMITTEE

W. F. Reavis, President, Waycross
 David Henry Poer, Secretary-Treasurer, Atlanta
 W. C. Elliott, Chairman of Council, Cuthbert
 D. Lloyd Wood, Member of Council, Dalton

DISTRICT SOCIETIES

OFFICERS AND MEETING DATES

First District

President—A. Bird Daniel, Statesboro
 Secretary—Wm. H. Fulmer, Savannah
 Third Wednesday—March and July.

Second District

President—C. K. Sharp, Arlington
 Secretary—Frank A. Little, Thomasville
 Second Thursday—April and October

Third District

President—Frank B. Schley, Columbus
 Secretary—T. Schley Gatewood, Americus
 Third Wednesday in June—Second Wednesday in November.

Fourth District

President—H. Hilt Hammett, Jr., LaGrange
 Secretary-Treasurer—James M. Bryant, Jr., Newnan
 Second Wednesday—February and August.

Fifth District

President—L. Minor Blackford, Atlanta
 Secretary—C. Purcell Roberts, Atlanta
 March and November

Sixth District

President—E. B. Claxton, Dublin
 Secretary-Treasurer—C. H. Richardson, Jr., Macon
 Last Wednesday in June—First Wednesday in December

Seventh District

President—Ralph Fowler, Marietta
 Secretary—R. D. Walter, Calhoun
 First Wednesday in April; last Wednesday in September.

Eighth District

President—L. W. Pierce, Waycross
 Secretary—Sage Harper, Douglas
 Second Tuesday—April and October.

Ninth District

President—A. E. Roper, Jasper
 Secretary—Hartwell Joiner, Gainesville
 April and September.

Tenth District

President—David R. Thomas, Augusta
 Secretary—A. W. Simpson, Jr., Washington
 Second Wednesday—February and August.

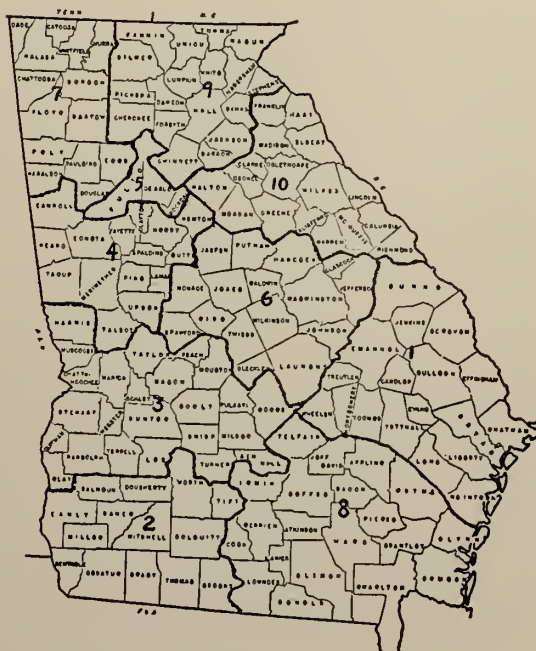
COUNCILORS

District	Councilor	Term Expires
1—	Lee Howard, Savannah	1952 Session
2—	C. K. Wall, Thomasville	1952 Session
3—	W. G. Elliott, <i>Chairman</i> , Cuthbert	1952 Session
4—	J. W. Chambers, LaGrange	1953 Session
5—	Marion C. Pruitt, Atlanta	1953 Session
6—	H. D. Allen, Jr., Milledgeville	1953 Session
7—	D. Lloyd Wood, Dalton	1953 Session
8—	Sage Harper, <i>Vice Chairman</i> , Douglas	1953 Session
9—	W. Bruce Schaefer, Toccoa	1954 Session
10—	H. L. Cheeves, Union Point	1954 Session

VICE-COUNCILORS

District	Vice-Councilor	Term Expires
1—	Chas. T. Brown, Guyton	1952 Session
2—	C. H. Watt, Thomasville	1952 Session
3—	Guy J. Dillard, Columbus	1952 Session
4—	Clarence B. Palmer, Covington	1952 Session
5—	John W. Turner, Atlanta	1953 Session
6—	H. G. Weaver, Macon	1953 Session
7—	M. M. Hagood, Marietta	1953 Session
8—	J. A. Leaphart, Jesup	1953 Session
9—	Charles R. Andrews, Jr., Canton	1954 Session
10—	J. Victor Roule, Augusta	1954 Session

GEORGIA CONGRESSIONAL DISTRICT



COMMITTEES

NOTE: Members of Standing Committees are ordinarily appointed for a period of three years and the senior member usually serves as chairman. Members of Special Committees serve until the time of the next Annual Session unless otherwise provided for.

STANDING COMMITTEES

SCIENTIFIC WORK—Richard Torpin, chairman, Augusta; Thomas L. Ross, Jr., vice-chairman, Macon; H. Ansley Seaman, Waycross; W. F. Reavis, Waycross; David Henry Poer, Atlanta.

PUBLIC POLICY AND LEGISLATION—Spencer A. Kirkland, chairman, Atlanta; C. C. Aven, Atlanta; Jack C. Norris, Atlanta; W. F. Reavis, Waycross; C. F. Holton, Savannah. (Sub-committee composed of one member nominated by each County and District Society).

MEDICAL EDUCATION AND HOSPITALS—G. Lombard Kelly, chairman, Augusta; R. Hugh Wood, Atlanta; C. H. Richardson, Sr., Macon.

MEDICAL DEFENSE—Marion C. Pruitt, chairman, Atlanta; B. H. Minchew, Waycross; Marcus Mashburn, Cumming; W. G. Elliott, Cuthbert; David Henry Poer, Atlanta.

PROFESSIONAL CONDUCT—Ralph H. Chaney, chairman, Augusta; Steve P. Kenyon, Dawson; Edgar H. Greene, Atlanta; Enoch Callaway, LaGrange; A. M. Phillips, Macon.

HISTORY AND VITAL STATISTICS—J. Calvin Weaver, chairman, Atlanta; Frank K. Boland, Atlanta; Ernest F. Wahl, Thomasville.

PUBLIC HEALTH—J. C. Brim, chairman, Pelham; C. L. Ayers, Toccoa; B. Hollis Hand, LaGrange. (Sub-committee composed of one member nominated by each County and District Society).

SPECIAL COMMITTEES

PUBLIC RELATIONS—Stephen T. Brown, chairman, Atlanta; C. C. Aven, vice-chairman, Atlanta; W. G. Elliott, Cuthbert; W. F. Reavis, Waycross; David Henry Poer, Atlanta; D. Lloyd Wood, Dalton.

WOMAN'S AUXILIARY—Ralph H. Chaney, chairman, Augusta; Steve P. Kenyon, Dawson; Edgar H. Greene, Atlanta; Enoch Callaway, LaGrange; A. M. Phillips, Macon.

INSURANCE AND ECONOMICS—W. S. Dorough, chairman, Atlanta; John L. Elliott, vice-chairman, Savannah; Kenneth D. Grace, LaGrange; W. L. Pomeroy, Waycross; D. Lloyd Wood, Dalton.

ORTHOPEDICS—J. Hiram Kite, chairman, Atlanta; Peter B. Wright, vice-chairman, Augusta; Thomas P. Goodwyn, Atlanta; F. Bert Brown, Savannah; John I. Hall, Macon; W. A. Newman, Macon; H. Walker Jernigan, Atlanta; C. E. Irwin, Warm Springs; Lawson Thornton, Atlanta; C. G. Henry, Augusta.

STUDENT LOAN FUND—Mrs. Shelley C. Davis, chairman, Atlanta; G. Lombard Kelly, Augusta; R. Hugh Wood, Atlanta.

AWARDS—C. H. Richardson, Sr., chairman, Macon; Mason I. Lowance, Atlanta; William R. Dancy, Savannah.

CONSTITUTION AND BY-LAWS—Enoch Callaway, chairman, LaGrange; W. F. Reavis, Waycross; Allen H. Bunce, Atlanta; A. M. Phillips, Macon; John A. Dunaway, Attorney for the Association, Atlanta; David Henry Poer, secretary-treasurer, Atlanta.

LIAISON COMMITTEE GEORGIA STATE MEDICAL ASSOCIATION (Negro)—J. F. Hanson, chairman, Macon; W. E. Storey, Columbus; Lee H. Battle, Jr., Rome; E. Van Buren, Atlanta; H. H. Allen, Decatur.

CANCER—J. Elliott Scarborough, chairman, Emory University; Everett L. Bishop, Atlanta; Robert C. Pendergrass, Americus; Thomas Harrold, Macon; Enoch Callaway, LaGrange; Lee Howard, Savannah; W. F. Jenkins, Columbus; Hoke Wammock, Augusta; D. M. Bradley, Waycross; John Funke, Atlanta; J. J. Collins, Thomasville; Max Mass, Macon; John L. Barner, Athens; Charles R. Andrews, Jr., Canton.

LIAISON COMMITTEE OF 53 CONSTITUENT STATE MEDICAL ASSOCIATIONS TO COORDINATE EDUCATIONAL PROGRAM OF THE A.M.A.—Jack C. Norris, Atlanta.

INDUSTRIAL HEALTH—C. N. Wasden, chairman, Macon.

REVISION OF PHARMACOPEIA OF U. S.—Allen H. Bunce, chairman (1960), Atlanta; C. C. Aven (1960), Atlanta; Hal M. Davison (1960), Atlanta.

PEDIATRICS—Philip A. Mulherin, chairman, Augusta; Don F. Cathcart, vice-chairman, Atlanta; Frank Schley, Columbus; Edwin R. Watson, Macon; M. M. McCord, Rome; Howard J. Morrison, Savannah; W. Charles Boswell, Macon; A. M. Johnson, Valdosta; C. M. Massey, Waycross.

MATERNAL CARE—H. F. Sharpley, Jr., chairman, Savannah; E. D. Colvin, vice-chairman, Atlanta; Guy V. Rice, Atlanta; John R. McCain, Atlanta; Hugh J. Bickert, Columbus.

FRATERNAL DELEGATES TO OTHER STATES

ALABAMA—Elwyn V. Patrick, Carrollton; Enoch Callaway, LaGrange; Willis P. Jordan, Jr., Brunswick.

FLORIDA—J. B. Avera, Brunswick; Steve P. Kenyon, Dawson; J. F. Mixson, Jr., Valdosta.

NORTH CAROLINA—Marion A. Hubert, Athens; R. Lee Rogers, Gainesville; W. Bruce Schaefer, Toccoa.

SOUTH CAROLINA—Wiley S. Flanagan, Augusta; F. Bert Brown, Savannah; Tyrus R. Cobb, Jr., Dublin.

TENNESSEE—Lee H. Battle, Jr., Rome; S. E. Andrew, Waycross; Truman W. Whitfield, Dalton.

STATE BOARD OF HEALTH*—First District: James M. Byne, Jr., Waynesboro, Sept. 1, 1957; Second District: A. G. Funderburk, Moultrie, Sept. 1, 1957; Third District: R. C. Montgomery, Butler, Sept. 1, 1954; Fourth District: M. M. Head, Zebulon, Sept. 1, 1955; Fifth District: Spencer A. Kirkland, Atlanta, Sept. 1, 1954; Sixth District: A. M. Phillips, Macon, Sept. 1, 1956; Seventh District: Fred H. Simonton, Chickamauga, Sept. 1, 1956; Eighth District: C. J. Maloy, McRae, Sept. 1, 1956; Ninth District: R. Lee Rogers, Gainesville, Sept. 1, 1956; Tenth District: Thos. W. Goodwin, Augusta, Sept. 1, 1955; **Georgia Dental Association** **—J. M. Hawley, Columbus, Sept. 1, 1952; J. G. Williams, Atlanta, Sept. 1, 1952; **Georgia Pharmaceutical Association** **—Preston Sumner, East Point, Sept. 1, 1953; A. T. McRae, Douglas, Sept. 1, 1956.

STATE BOARD OF MEDICAL EXAMINERS—Fred J. Coleman, Dublin; Edgar H. Greene, Atlanta; J. W. Palmer, Ailey; Steve P. Kenyon, Dawson; Grady N. Coker, Canton; R. H. McDonald, Newnan; A. M. Deal, Statesboro; Alexander B. Russell, Winder; Rufus A. Askew, Atlanta; W. H. Powell, Hazlehurst.

WOMAN'S AUXILIARY OFFICERS 1951-1952—President, Mrs. J. R. S. Mays, Macon; President-Elect—Mrs. Ralph Fowler, Marietta; First Vice President—Mrs. T. A. Peterson, Savannah; Second Vice President—Mrs. R. C. McGahee, Augusta; Third Vice President—Mrs. Leo Smith, Waycross; Recording Secretary—Mrs. Virgil Williams, Griffin; Treasurer, Mrs. M. T. Edgerton, Atlanta; Historian, Mrs. Ralph McCord, Rome; Corresponding Secretary—Mrs. Rhea Richardson, Macon; Parliamentarian—Mrs. Ralph Chaney, Augusta.

*Nominated by their respective district medical societies and appointed for six-year terms.

**—Nominated by their respective associations.

THE MEDICAL ASSOCIATION OF GEORGIA

COUNTY MEDICAL SOCIETY DIRECTORY

(Send in changes and corrections promptly)

COUNTY	PRESIDENT	SECRETARY
Appling	J. D. Brown, Jr., Baxley	James A. Bedingfield, Baxley
Baldwin	Wallace M. Gibson, Milledgeville	Robert D. Waller, Milledgeville
Bartow	Wm. B. Quillian, Jr., Cartersville	A. L. Horton, Cartersville
Ben Hill	Roy Johnson, Jr., Fitzgerald	W. C. Sams, Jr., Ocilla
Bibb	Robert W. Edenfield, Macon	Henry H. Tift, Macon
Blue Ridge	Courtney C. Brooks, Blue Ridge	Thos. J. Hicks, McCaysville
Brooks	A. B. Jones, Jr., Quitman	Walter G. Thwaite, Quitman
Bulloch-Candler-Evans	Curtis G. Hames, Claxton	Louie H. Griffin, Claxton
Burke	D. L. Butterfield, Waynesboro	C. Thompson, Jr., Waynesboro
Carroll-Douglas-Haralson	F. W. Morgan, Douglasville	D. S. Reese, Carrollton
Georgia Med. Society (Chatham County)	J. H. Pinholster, Savannah	Lawrence Lee, Jr., Savannah
Chattooga	Wm. T. Gist, Summerville	Wm. U. Hyden, Trion
Cherokee-Pickens	Chas. R. Andrews, Jr., Canton	A. M. Hendrix, Canton
Clarke-Madison-Oconee	C. H. Bryant, Comer	Wm. C. Kitchens, Athens
Clayton-Fayette	T. J. Busey, Fayetteville	Richard P. Campbell, Fayetteville
Cobb	E. A. Musarra, Marietta	Bruce D. Burleigh, Marietta
Coffee	H. G. Joiner, Douglas	Sage Harper, Douglas
Colquitt	John F. McCoy, Moultrie	John W. McLeod, Moultrie
Coweta	H. D. Meaders, Newnan	J. H. Arnold, Newnan
Crisp	C. E. McArthur, Cordele	O. T. Gower, Jr., Cordele
Decatur-Seminole	Jones T. Wright, Donalsonville	M. A. Ehrlich, Bainbridge
DeKalb	Richard H. Smoot, Decatur	Chester W. Morse, Decatur
Dooley	W. K. Coleman, Vienna	Martin L. Malloy, Vienna
Dougherty	C. M. Holman, Albany	Paul T. Russell, Albany
Elbert	A. S. Johnson, Elberton	John B. O'Neal, III, Elberton
Emanuel	S. S. Youmans, Swainsboro	H. W. Smith, Swainsboro
Floyd	Lee H. Battle, Jr., Rome	Russell E. Andrews, Jr., Rome
Forsyth	Marcus Mashburn, Jr., Cumming	Jim Mashburn, Cumming
Franklin	Stewart D. Brown, Royston	E. T. Poole, Lavonia
Fulton	Jack C. Norris, Atlanta	Tully T. Blalock, Atlanta
Glynn	Ira G. Towson, Sea Island	Thos. H. Johnston, Brunswick
Gordon	R. D. Walter, Calhoun	Lewis R. Lang, Calhoun
Grady	A. B. Reynolds, Cairo	J. V. Rogers, Cairo
Greene	F. H. Killam, Greensboro	
Gwinnett	Jos. Robert Chastain, Buford	Miles Herbert Mason, Duluth
Habersham	Joe J. Arrendale, Cornelia	J. L. Walker, Clarksville
Hall	Benjamin Nalley, Helen	Martin H. Smith, Gainesville
Hancock	H. L. Earl, Sparta	
Hart	George T. Harper, Dewy Rose	Louis G. Cacchioli, Hartwell
Henry	H. C. Ellis, McDonough	G. R. Foster, Jr., McDonough
Houston-Peach	A. Smoak Marshall, Vt. Valley	A. G. Hendrick, Perry
Jackson-Barrow	J. T. Stovall, Jefferson	L. W. Moore, Winder
Jasper	F. S. Belcher, Monticello	E. M. Lancaster, Shady Dale
Jefferson	John R. Lewis, Louisville	James W. Pilcher, Louisville
Jenkins	James F. Freeman, Sylvania	A. P. Mulkey, Millen
Lamar	J. H. Jackson, Barnesville	S. B. Traylor, Barnesville
Laurens	James L. Bush, Dublin	Robert T. Anderson, Dublin
Macon		Thos. M. Adams, Montezuma
Meriwether-Harris	Thomas Gucker, III, Warm Springs	R. B. Gilbert, Greenville
Mitchell	J. C. Pirkle, Pelham	A. A. McNeill, Jr., Camilla
Monroe	A. Walter Bramblett, Jr., Forsyth	George H. Alexander, Forsyth
Montgomery	W. M. Moses, Uvalda	J. W. Palmer, Ailey
Morgan	J. H. Nicholson, Madison	W. C. McGeary, Madison
Muscogee	E. K. Munn, Columbus	E. J. Cain, Columbus
Newton	F. C. Nesbit, Covington	Clarence B. Palmer, Covington
Ocmulgee	Edward G. Jones, Eastman	James L. Thomson, Eastman
Polk	Wm. H. Blanchard, Cedartown	Cecil B. Elliott, Cedartown
Rabun	L. Neville, Dillard	J. C. Dover, Clayton
Randolph-Terrell	C. M. Pugh, Lumpkin	W. G. Elliott, Cuthbert
Richmond	Thos. W. Goodwin, Augusta	W. K. Philpot, Augusta
Rockdale		Harvey E. Griggs, Conyers
Screven	James A. Freeman, Sylvania	W. G. Simmons, Sylvania
South Ga. Med. Society	E. Harry Mixson, Valdosta	Alexander G. Little, Jr., Valdosta
Spalding	John Venable, Griffin	John E. Clouse, Jr., Griffin
Stephens	Robt. E. Shiflet, Toccoa	C. L. Ayers, Toccoa
Sumter	Wm. B. McMath, Americus	Bon M. Durham, Americus
Tattnall	J. M. Hughes, Glennville	A. G. Pinkston, Jr., Glennville
Taylor	Lewis Beason, Butler	E. C. Whatley, Reynolds
Telfair	F. A. Smith, Jr., McRae	F. R. Mann, McRae
Thomas	Marion A. Baldwin, Thomasville	Kirk Shepard, Thomasville
Tift	Robert E. Jones, Tifton	Tom L. Edmondson, Tifton
Toombs	W. W. Aiken, Lyons	R. H. DeJarnette, Vidalia
Tri-County (Calhoun- Early-Miller)	James H. Crowdis, Jr., Blakely	Hinton J. Merritt, Colquitt
Tri-County (Liberty-Long- McIntosh)		O. D. Middleton, Ludowici
Troup	Willis M. Hendricks, LaGrange	Wm. B. Fackler, LaGrange
Turner	Member, J. H. Baxter, Ashburn	
Upson	Douglas L. Head, Jr., Thomaston	James A. Woodall, Thomaston
Walker-Catoosa-Dade	John P. Hoover, Rossville	Thos. W. Alsobrook, Rossville
Walton	Lynn M. Huie, Monroe	Harry B. Nunnally, Monroe
Ware	W. C. Calhoun, Waycross	Leo Smith, Waycross
Warren	H. B. Cason, Warrenton	A. W. Davis, Warrenton
Washington	Joseph E. Lever, Sandersville	Farris T. McElreath, Jr., Tennesse
Wayne	James W. Yeomans, Jesup	Fred M. Harper, Jesup
Whitfield	E. A. Rosen, Dalton	Albert M. Boozer, Dalton
Wilcox	V. L. Harris, Rochelle	J. D. Owens, Rochelle
Wilkes	C. E. Wills, Jr., Washington	M. C. Adair, Washington
Worth	J. L. Tracy, Jr., Sylvester	H. G. Davis, Jr., Sylvester

OFFICERS OF ALLIED ORGANIZATIONS

(All organizations with interests in the medium field, are invited to send in similar information.—Ed.)

AMERICAN CANCER SOCIETY, GEORGIA DIVISION

President—Enoch Callaway, M. D., LaGrange.
Secretary—Mr. Lon Sullivan, 179 Spring St., N. W., Atlanta

AMERICAN RED CROSS

Medical Director of Southeastern Area—George Dowling, M.D., 848 Peachtree St., N. E., Atlanta.

BETTER HEALTH COUNCIL OF GEORGIA

Chairman Executive Board—Mrs. Shelley C. Davis.
Vice Chairman—Mrs. Fred Knight
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Meeting—Macon, October 23, 1952.

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Secretary—James H. Semans, M. D., 34 Seventh St., Atlanta.
Meeting—Columbus, October, 1952.

GEORGIA CHAPTER, ARTHIRITIS AND RHEUMATISM FOUNDATION

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GEORGIA HEART ASSOCIATION

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Secretary—J. Willis Hurst, M.D., Emory University Hospital, Emory University.
Executive Secretary—Mr. Linwood Beck, 11 Pryor St., S. W., Atlanta.
Meeting—General Oglethorpe Hotel, Savannah, September 12, 13, 1952.

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President—Walker H. Matthews, O. D., Box 1426, Athens.
 Secretary-Treasurer—Jack A. Wheeler, O. D., Box 601, Elberton.
 Convention—Hotel Bon Air, Augusta, January 20, 21, 22, 1952.

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President—John A. Simpson, M.D., 1010 Prince Ave., Athens.
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 Treasurer—Mr. J. L. Hawks, 277 W. Wesley Rd., N. W., Atlanta
 Secretary—Mr. J. T. Selman, Grand Theatre Bldg., Atlanta
 Meeting—DeSoto Hotel, Savannah, April 28, 29, 30, 1952.

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President—Lloyd Osteen, M.D., 610 Anderson Ave., Savannah.
 Secretary-Treasurer—David A. Davis, M.D., Medical College of Georgia, Augusta.
 Meeting—Biltmore Hotel, Atlanta, May, 1952.

GEORGIA SOCIETY FOR CRIPPLED CHILDREN, INC.

Executive Director—Miss Mary Webb, 715-19 Grand Theatre Bldg., Atlanta.
 President—Herman L. Turner, D.D., 2461 Peachtree Rd., N. E., Atlanta.
 Meeting—Atlanta, October, 1952.

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GEORGIA STATE LEAGUE OF NURSING EDUCATION

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President—Rufus F. Payne, M.D., Battey State Hospital, Rome.
 Secretary-Treasurer—Samuel E. Patton, M.D., Persons Bldg., Macon.
 Meetings—Atlanta, May 11-14, 1952; Battey State Hospital, Rome, November 1952.

GEORGIA TUBERCULOSIS ASSOCIATION

President—Mr. Julian Sipple, P. O. Box 527, Savannah.
 Executive Secretary—Mr. Carl Fox, Chamber of Commerce Bldg., Atlanta
 Meeting—Dempsey Hotel, Macon, June 5, 6, 7, 1952.

GEORGIA UROLOGICAL SOCIETY

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 Vice President—Ben T. Beasley, M.D., Hurt Bldg., Atlanta.
 Secretary-Treasurer—A. H. Letton, M.D., 478 Peachtree St., N. E., Atlanta.
 Meeting—Southern Regional Meeting, Birmingham, Ala., Feb. 15-16, 1952.

SOUTHEASTERN SURGICAL CONGRESS

President—Joseph S. Stewart, M.D., 803 DuPont Bldg., Miami, Fla.
 Vice President—George W. Fuller, M.D., 478 Peachtree St., N. E., Atlanta.
 President-Elect—Harry L. Claud, M.D., 1757 N. St., N. W., Washington, D. C.
 Secretary-Treasurer—B. T. Beasley, M.D., 701 Hurt Bldg., Atlanta.
 Meeting—Biltmore Hotel, March 10, 11, 12, 13, 1952.

ASSOCIATED WOMEN OF THE GEORGIA FARM BUREAU FEDERATION

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AMERICAN ASSOCIATION OF SOCIAL WORKERS, GEORGIA CHAPTER

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President—Mrs. Amanda Reese, 1035 Mayson Turner Ave., N. W., Atlanta.

MEMBERSHIP ROSTER

of the

MEDICAL ASSOCIATION OF GEORGIA

(To make the membership roster as accurate as possible letters, cards, and questionnaires have been sent to secretaries of all county societies. However, doctors are a "gypsy group" and some changes of address or status will take place before this reaches the printer. Indicate corrections direct to your secretary, and he will keep this office posted.—Ed.)

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Bedingfield, James, A., Baxley
Branch, W. D., Baxley
Brown, J. D., Jr., Baxley
Holt, J. T., Baxley
Kennedy, F. D., Baxley
McCracken, H. C., Baxley
Ohlmacher, A. P., Baxley

BALDWIN COUNTY

Allen, E. W., Milledgeville
Allen, H. D., Jr., Milledgeville
Bailey, L. A., Milledgeville
Binion, Richard, Milledgeville
(Hon.)
Bradford, R. W., Milledgeville
Cary, H. R., Milledgeville
Chesnutt, T. H., Milledgeville
Clodfelter, Thos. C., Milledgeville
Echols, Geo. L., Milledgeville
Fulghum, C. G., Milledgeville
Fussell, J. K., Milledgeville
Gibson, Wallace M., Milledgeville
Hall, Thomas M., Milledgeville
(Hon.)
Hatcher, Lewis Lamar, Milledgeville
Parks, Francis M., Milledgeville
Peacock, Thomas C., Milledgeville
Pennington, L. E., Terrell State
Hospital, Terrell, Tex.
Pennington, Veronica Murphy, Terrell State Hospital, Terrell, Tex.
Pursley, Norman B., Gracewood
Smith, M. E., Milledgeville
Walker, E. Y., Milledgeville
Waller, Robert D., Milledgeville
Wiley, John D., Milledgeville
Williams, David C., Milledgeville
Woods, O. C., Milledgeville
Yarbrough, Y. H., Milledgeville

BANKS COUNTY

Jolley, J. S., Homer

BARTOW COUNTY

Bradford, H. B., Cartersville
Dillard, William B., Jr., Cartersville
Horton, A. L., Cartersville
Howell, S. M., Cartersville
*Howell, W. Harvey, Cartersville
McGowan, Hugh S., Cartersville
Quillian, Wm. B., Jr., Cartersville
Stanford, J. W., Cartersville
Whately, L. R., Cartersville
Wofford, W. E., Cartersville

BEN HILL COUNTY

Coffee, W. P., Fitzgerald
Cornwell, Gibson K., Fitzgerald
Dismuke, H. L., Ocilla

Harper, A. Wray (Hon.)
Johnson, Roy, Jr., Fitzgerald
McElroy, S. L., Ocilla
McMillan, J. E., Fitzgerald
Sams, William C., Jr., Ocilla
Smith, J. E., Fitzgerald
Ward, Francis, Fitzgerald
Ware, D. B., Fitzgerald
Willcox, W. D., Fitzgerald
Willis, G. W., Ocilla

BIBB COUNTY

Aldrich, Fred N., Professional Bldg.,
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Macon
Anderson, J. C., 719 Persons Bldg.,
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Applewhite, J. D., 700 Spring St.,
Macon
Atkinson, H. C., 700 Spring St.,
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Macon
Baxley, W. W., Persons Bldg.,
Macon
Bazemore, W. L., 553 Walnut St.,
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Benton, C. C., 203 Professional
Bldg., Macon
Billinghurst, George A., Persons
Bldg., Macon
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Macon
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morial Hospital, Atlanta (Asso.)
Daniel, Joe Wesley, Jr., Macon Hos-
pital, Macon
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(Hon.)
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Goldstein, J. Jay, Warner Robins
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Hall, T. H., Grand Bldg., Macon
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Hogan, Jasper T., Jr., 3828 The
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Houser, Frank M., Grand Bldg.,
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Jones, Rudolph W., Jr., 959 Daisy
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King, J. L., Persons Bldg., Macon
King, J. Lon, Jr., Persons Bldg.,
Macon
Lewis, W. Earl, Persons Bldg.,
Macon
Mass, Max, Macon Hospital, Macon
Massenburg, G. Y., 557 Walnut St.,
Macon
Mays, J. R. S., 700 Spring St.,
Macon
McAllister, Robert W., 700 Spring
St., Macon
McFarlane, John W., 201 Profes-
sional Bldg., Macon
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Ins. Bldg., Macon
McMichael, V. H., Clinic Hospital,
Macon

* In Military Service.

McMillan, E. C., Jr., 219 Bibb Bldg., Macon
 Meriwether, W. W., Persons Bldg., Macon
 Meserve, Francis B., 721 McArthur Blvd., Warner Robins
 Mobley, W. E., 563 College St., Macon (Hon.)
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 Richardson, C. H., Jr., 700 Spring St., Macon
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 Ridley, C. L., Macon Hospital, Macon
 Ridley, C. L., Jr., Persons Bldg., Macon
 Rogers, T. E., 120 Clisby Place, Macon (Hon.)
 Rogers, Thomas E., Jr., 700 Spring St., Macon
 Ross, Thos. L., Jr., 700 Spring St., Macon
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 Rumble, Charles T., 700 Spring St., Macon
 Rutland, S. C., Ga. Dept. of Public Health, Atlanta
 Siegel, Alvin E., Medical Arts Bldg., Macon
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 Smith, J. Allen, 700 Spring St., Macon
 Stamps, Edward Roe, Bibb Bldg., Macon
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 Suarez, Raymond, Medical Arts Bldg., Macon
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Wadsen, C. N., Bankers Ins. Bldg., Macon
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 Nevil, J. L., Metter
 Neville, J. C., Register (Hon.)
 Olliff, H. H., Register
 Patrick, J. Z., Pulaski (Hon.)
 Simmons, W. E., Metter
 Stapleton, C. E., Statesboro
 Whiteside, J. H., Statesboro

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 McCarver, W. C., Vidette
 Thompson, Cleveland, Waynesboro
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 Brown, Walter E., 14 West Hull St., Savannah
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 Coward, Allen W., 17 East Jones St., Savannah
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 Crawford, W. B., 14 East Taylor St., Savannah
 Crawford, W. B., Jr., 14 East Taylor St., Savannah
 Dabbs, C. H., USPH Hospital, Savannah (Asso.)
 Dancy, Wm. R., 102 West Jones St., Savannah
 Daniel, J. W., 26 East 31st St., Savannah (Hon.)
 Daniel, J. W., Jr., 5 East Jones St., Savannah

deCaradeuc, St. J. R., DeRenne Apts., Savannah
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 Edwards, D. B., Ellabell (Hon.)
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 Elliott, J. L., 212 East Huntingdon St., Savannah
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 Fillingim, D. B., 118 East Jones St., Savannah
 Fleming, Paul N., 14 West Taylor St., Savannah
 *Frech, H. C., 516 East 53rd St., Savannah (Asso.)
 Freedman, L. M., 1½ East Gordon St., Savannah
 Freeman, Thomas R., 513 Whitaker St., Savannah
 Fulmer, Wm. H., 19 East 34th St., Savannah
 Gleaton, E. N., 2 East Jones St., Savannah
 Goldenstar, Grant W., 106 East Jones St., Savannah
 Gottschalk, Robert B., 123 East Jones St., Savannah
 Graham, R. E., 212 East Gaston St., Savannah
 Ham, Emerson, 414 Bull St., Savannah
 Henderson, Clair A., 25 East Charlton St., Savannah
 Holloman, A. L., 119 East Jones St., Savannah
 Holton, C. F., DeRenne Apartments, Savannah
 Hopkins, Anne, 22 East Jones St., Savannah
 Howard, Lee, DeRenne Apts., Savannah
 Howard, Lee, Jr., DeRenne Apts., Savannah
 Howkins, John S., 111 East Jones St., Savannah
 Johnson, G. H., Jr., 126 East Oglethorpe Ave., Savannah
 Jones, Jabez, 11 West Gordon St., Savannah
 Kandel, H. M., 432 Abercorn St., Savannah
 Kanter, W. W., 345 Bull St., Savannah
 Kelley, Albert J., 4 East Taylor St., Savannah
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 Lang, G. H., 202 East Liberty St., Savannah
 Lange, Stephen J., 12 East Taylor St., Savannah
 Lee, Lawrence, DeRenne Apts., Savannah

Lee, Lawrence, Jr., 113 East Gwinnett St., Savannah
 Levington, H. L., 209 East Gaston St., Savannah
 Long, W. V., DeSoto Hotel, Savannah
 Lott, Oscar H., 111 East Jones St., Savannah
 Lynn, S. C., 124 East Jones St., Savannah
 Maner, E. N., 101 East 45th St., Savannah (Hon.)
 Martin, R. V., 18 East 31st St., Savannah
 Massoud, M. A., Pineora (Hon.)
 Mazo, Milton M., 8 East Taylor St., Savannah
 McGee, H. H., 7 West Gordon St., Savannah
 McGoldrick, Thomas A., Jr., 15 East Gordon St., Savannah
 McLean, Jay, 612 Drayton St., Savannah
 Metts, J. C., 427 Bull St., Savannah
 Morrison, Howard J., 444 Drayton St., Savannah
 Nagel, L. R., U. S. Communicable Disease Center, Savannah (Asso.)
 Neville, R. L., 11 West Gordon St., Savannah
 *Nichols, F. T., 102 E. Gwinnett St., Savannah (Asso.)
 Norton, W. A., 105 East Oglethorpe Ave., Savannah (deceased)
 Oliver, R. L., DeRenne Apts., Savannah
 Olmstead, G. T., 20 East Taylor St., Savannah
 O'Neill, J. C., 202 East Liberty St., Savannah
 Osborne, E. S., 19 East Jones St., Savannah
 *Osborne, W. W., 631 Washington Ave., Savannah (Asso.)
 Osteen, W. L., 610 Anderson Ave., Savannah
 Pacifici, Joseph, 2 East Taylor St., Savannah
 Peterson, T. A., 11 West Jones St., Savannah
 Pinholster, J. H., 241 Abercorn St., Savannah
 Porter, J. E., 128 East Taylor St., Savannah
 Portman, Henry J., Jr., 9 East Gordon St., Savannah
 Powers, L. K., 29 East Jones St., Savannah
 Prince, Chas. L., 2515 Habersham St., Savannah
 Quattlebaum, J. K., 24 West Gaston St., Savannah
 Rahban, L. J., 314 East Gaston St., Savannah
 Redmond, C. G., 701 Whitaker St., Savannah
 Redmond, C. R. A., 530 East 49th St., Savannah
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 *Rollings, H. E., U. S. Air Force (Asso.)
 Rosen, E. F., 5 East Gordon St., Savannah

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 Sax, Charles E., 19 West Liberty St., Savannah
 Scardino, Peter L., 2515 Habersham St., Savannah
 Schley, R. L., Jr., 114 West Gaston St., Savannah
 Schneider, M. M., 12½ West Taylor St., Savannah
 Sharpley, H. F., Jr., DeRenne Apts., Savannah
 Sharpley, Helen, 1017 Abercorn, Savannah
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 Shearouse, J. Wm., 14 East Taylor St., Savannah
 Smith, H. M., 9 West Gordon St., Savannah
 Smith, P. H., 127 East Gordon St., Savannah
 Stalvey, J. K., Jr., 114 East Jones St., Savannah
 Straight, G. W., 304 East Huntingdon St., Savannah
 Taylor, L. B., 601 Whitaker St., Savannah (Hon.)
 Train, J. K., 1107 Bull St., Savannah (Hon.)
 Train, J. K., Jr., 1107 Bull St., Savannah
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 Usher, Charles, 6 East Liberty St., Savannah
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 Waring, Ruth Moyer, 905 East Duffy St., Savannah
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 Whelan, E. J., 14 West Jones St., Savannah
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 Williams, L. W., 105 East Jones St., Savannah
 Wilson, W. D., 104 West Waldburg St., Savannah
 Withington, John C., 106 West Jones St., Savannah
 Youngblood, Samuel, Jr., 108 East Taylor St., Savannah
 Zirkle, J. G., 722 Drayton St., Savannah

CHATTOOGA COUNTY

Allen, John J., Trion
 Gist, William T., Summerville
 Goodwin, Hugh A., Jr., Summerville
 Hyden, Wm. U., Trion
 Little, G. H., Trion
 Little, R. N., Summerville

CHEROKEE-PICKENS COUNTIES

Andrews, Charles R., Jr., Canton
 Brooke, George C., Canton (deceased)

* In Military Service.

Coker, Grady N., Canton
 Hendrix, A. M., Canton
 Hendrix, M. G., Ball Ground (Hon.)
 Jones, Robert T., III, Canton
 Looper, Ben K., Canton
 Moore, R. M., Waleska (Hon.)
 Perrow, G. H., Jasper
 Roper, C. J., Jasper
 Roper, E. A., Jasper
 Vansant, T. J., Wodstock

CLARKE-MADISON-OCONEE COUNTIES

Barner, John L., Athens Gen. Hos-
 pital, Athens
 Bond, D. T., Danielsville
 Bonner, William H., 130 W. Han-
 cock Ave., Athens
 Brown, W. W., City Health Dept.,
 Athens
 Bryant, C. H., Comer
 *Burroughs, W. F., U. S. Navy
 (Asso.)
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 Cabaniss, W. H., Sou. Mutual Bldg.,
 Athens
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 Florence, Loree, Sou. Mutual Bldg.,
 Athens
 Gallis, Anthony H., Georgian Hotel,
 Athens
 Gerdine, Linton, Sou. Mutual Bldg.,
 Athens
 Goldsmith, L. H., Sou. Mutual Bldg.,
 Athens
 Green, James A., Jr., 1010 Prince
 Ave., Athens
 Gustin, Ronald M., 530 Holman
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 Harris, H. B., 1010 Prince Ave.,
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 Harrison, W. B., City Health Dept.,
 Athens
 Holliday, Henry C., Sou. Mutual
 Bldg., Athens
 Hubert, M. A., 1010 Prince Ave.,
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 Ave., Athens
 Kitchens, Wm. C., 130 W. Hancock
 Ave., Athens
 Maxwell, Edgar J., Jr., 719 Jack-
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 McPherson, John T., Jr., 1010
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 Middlebrooks, C. O., Holman Hotel,
 Athens (Hon.)
 Moss, W. L., Jefferson Road, Athens
 (Hon.)
 Mullins, D. F., Jr., St. Mary's Hos-
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 Veale, Emory O., Arnoldsville
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 Infirmary, Athens
 Welchel, G. O., Sou. Mutual Bldg.,
 Athens
 Whitley, L. L., Sou. Finance Bldg.,
 Athens

CLAYTON-FAYETTE COUNTIES

Busey, T. J., Fayetteville
 Campbell, R. P., Fayetteville
 Coleman, Y. R., Jonesboro
 Robak, J. L., Jonesboro
 Wallis, J. R., Lovejoy

COBB COUNTY

Bannister, C. D., Route 1, Marietta
 Benson, Earl B., 304 Cherokee St.,
 Marietta
 Benson, W. H., Jr., 213 Cherokee
 St., Marietta
 Burleigh, Bruce D., 515 Clay St.,
 Marietta
 Busch, John F., Jr., 310 McDonough
 St., Marietta
 Bussey, J. G., Austell
 Butner, J. H., Powder Springs
 Cauble, George, Acworth
 Clark, F. B., Austell
 Colquitt, Alfred O., Jr., 215 Cher-
 okee St., Marietta
 Colquitt, Hugh S., Smyrna
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 St., Marietta
 Fowler, A. H., Marietta
 Fowler, R. W., Marietta
 Garland, C. M., Jr., Smyrna
 Garrett, Luke G., Jr., Austell
 Gober, W. Mayes, 304 Cherokee St.,
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 Hagood, G. F., Marietta
 Hagood, M. M., Marietta
 Inglis, E. P., Jr., 1607 Roswell St.,
 Marietta
 Lester, J. E., Marietta
 Levy, M. S., Smyrna
 Lindley, F. P., Powder Springs
 Marks, Edward S., 261½ North
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 McCall, M. N., Jr., Acworth
 Mitchell, W. C., Smyrna
 Musarra, E. A., 220 Church St.,
 Marietta
 Perkinson, W. H., 819 Church St.,
 Marietta
 Teem, Martin Van B., 502 Cherokee
 St., Marietta
 VanSant, Thomas J., 205 Lawrence
 St., Marietta

COFFEE COUNTY

Clark, T. H., Douglas (Hon.)
 Harper, Sage, Douglas

Jardine, Dan A., Douglas
 Johnson, R. L., Douglas
 Joiner, H. G., Douglas
 *Meeks, Calvin S., Jr., (Asso.) U.
 S. Air Force, Hunter Field,
 Savannah
 Oliver, James A., Douglas
 Quillian, B. O., Douglas
 Ricketson, G. M., Douglas
 Shellhouse, L. H., Willacoochee
 Wallace, J. W., Douglas

COLQUITT COUNTY

Baggs, Wade H., Jr., Moultrie
 Brannen, Cecil N., Moultrie
 Conger, P. D., Moultrie
 Fike, Rupert H., Moultrie
 Fokes, Robert E., Jr., Moultrie
 Funderburk, A. G., Moultrie
 Gay, Frank M., Moultrie
 Holmes, Edgar C., Moultrie
 Joiner, R. M., Moultrie
 Lanier, J. E., Moultrie (Hon.)
 McCoy, John F., Moultrie
 McGinty, W. R., Moultrie
 McLeod, John W., Moultrie
 Paulk, J. R., Moultrie
 Stegall, Robert E., Moultrie
 Stone, J. C., Doerun (Hon.)
 Whittendale, Wm. H., Norman
 Park (Hon.)
 *Withers, Samuel M., Moultrie
 (Asso.)
 Woodall, J. B., Moultrie

COLUMBIA COUNTY

Moon, Jack Bennett, Harlem
 Saggus, John G., Harlem

COWETA COUNTY

Arnold, J. H., Newnan
 Barksdale, C. R., Grantville
 Bryant, James M., Jr., Newnan
 Cochran, M. F., Newnan
 Elliott, C. C., Sargent
 Farmer, C. W., Jr., Newnan
 Glover, H. C., Jr., Newnan
 Glover, N. B., Newnan
 Hammond, G. W., Newnan
 Jackson, Bruce, Route 1, Newnan
 Kinnard, George P., Newnan
 McDonald, R. H., Newnan
 Meaders, H. D., Newnan
 Parks, Joseph W., Jr., Newnan
 Peniston, J. B., Newnan
 St. John, Jas. O., Newnan
 Tanner, W. H., Route 2, Newnan
 Tribble, J. M., Senoia
 Woodroof, Wm. L., Newnan (de-
 ceased)

CRISP COUNTY

Adams, Charles, Cordele (deceased)
 Dorminy, J. N., Cordele (Hon.)
 Goss, C. C., Ashburn
 Goss, Woodrow, Ashburn
 Gower, O. T., Jr., Cordele
 McArthur, Chas. E., Cordele
 Williams, H. J., Cordele
 Williams, L. E., Cordele
 Williams, P. L., Cordele
 Williams, P. L., Jr., Cordele
 Wootten, L. O., Cordele

* In Military Service.

DECATUR-SEMINOLE

Baxley, Harry B., Blakely
 Bellville, Chas. G., Bainbridge
 Bridges, E. C., R.F.D., Donalsonville
 Bridges, Henry A., Bainbridge
 Chason, Gordon, Bainbridge
 Ehrlich, M. A., Bainbridge
 Fort, M. A., Bainbridge
 Jenkins, H. B., Donalsonville
 Moseley, E. E., Donalsonville
 Spooner, John I., Donalsonville
 (Hon.)
 Tucker, John P., Bainbridge
 Welch, Carl B., Attapulgus
 Wheat, R. F., Bainbridge
 Wilkinson, W. L., Bainbridge
 Willis, L. W., Bainbridge
 Wright, Jones Thomas, Donalsonville

DeKALB COUNTY

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 Beck, John E., 356 W. Ponce de Leon Ave., Decatur
 Bloomer, Wm. E., 520 Church St., Decatur
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 Lee, Howard B., Masonic Temple Bldg., Decatur
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 Mendenhall, W. A., Chamblee
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 Nardone, A. J., 68 Avondale Rd., Decatur
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 Smoot, Richard H., 215 Church St., Decatur
 Stewart, Thos. W., Lithonia
 Taylor, John E., Jr., 356 W. Ponce de Leon Ave., Decatur

Vinson, T. O., DeKalb County Board of Health, Decatur
 Vogt, Elkin, Lithonia

DOOLY COUNTY

Coleman, O. K., Vienna
 Daves, V. C., Vienna
 Davis, E. B., Byronville
 Kitchens, O. W., Byronville
 Malloy, Martin L., Vienna
 McRee, Christine E., Unadilla
 McRee, Jean Douglas, Unadilla
 Mobley, H. A., Vienna (Hon.)

DOUGHERTY COUNTY

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 Barnett, J. M., Albany (deceased)
 Berg, Joseph L., 305 N. Jefferson St., Albany
 Bowman, M. B., 403 Broad Ave., Albany
 Cook, W. S., 238½ Pine Ave., Albany
 Dunn, Robert G., Jr., 1150 Julia St., Albany
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 Hilsman, P. L., 200½ Broad Ave., Albany
 Holman, C. M., 220½ Broad Ave., Albany
 Ingram, Lillian, 210 Callaway Bldg., Albany
 Irvin, I. W., C. & S. Bank Bldg., Albany
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 Keaton, J. C., C. & S. Bank Bldg., Albany
 Lamb, Charles C., Phoebe Putney Mem. Hospital, Albany
 Lucas, I. M., 222½ Broad Ave., Albany
 Mann, D. S., Medical Bldg., Albany
 McCall, Charles S., Jr., Liberty Theatre Bldg., Albany
 McDaniel, J. Z., C. & S. Bank Bldg., Albany
 McKemie, H. M., C. & S. Bank Bldg., Albany
 McKemie, W. Frank, Medical Bldg., Albany
 Neill, F. K., 100 N. Washington St., Albany
 Parrish, Lewis H., Allen Bldg., Albany
 Redfearn, J. A., 222½ Broad Ave., Albany
 Rhine, W. P., 403 Broad Ave., Albany
 Roberson, Phil E., Callaway Bldg., Albany
 Russell, Paul T., 220½ Broad Ave., Albany
 Seymour, Glenn E., 403 Broad Ave., Albany
 Sutton, J. Mack, Jr., 412 Third Ave., Albany
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ELBERT COUNTY

Bailey, D. V., Elberton
 Johnson, A. S., Elberton
 Johnson, A. S., Jr., Elberton
 Johnson, J. E., Elberton (Hon.)
 Johnson, J. E., Jr., Elberton
 Johnson, W. A., Elberton
 Mattox, B. B., Elberton (Hon.)
 Mickel, Carey A., Jr., Elberton
 O'Neal, John B., III, Elberton
 O'Neal, Phyllis J., Elberton
 Smith, A. C., Elberton (Hon.)
 Smith, F. A., Elberton
 Thompson, D. N., Elberton
 Ward, G. A., Route 1, Elberton

EMANUEL COUNTY

Brown, R. G., Swainsboro
 Powell, C. E., Swainsboro
 Youmans, S. S., Swainsboro

FLOYD COUNTY

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 Battle, Lee H., Jr., 321 W. Seventh, Rome
 Black, Robert J., Rome
 Blalock, Frank A., Battey State Hospital, Rome
 Bosworth, Ed. L., Harbin Clinic, Rome
 Brannon, Emmett, McCall Hospital, Rome
 Brooks, Wm. H., Lindale
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 Crow, H. E., Battey State Hospital, Rome
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 Dawson, Harry, Shannon
 Dellinger, Raiden W., 321 W. Seventh St., Rome
 Garner, J. S., Jr., 5 Cherokee St., Rome
 Garrard, J. L., 429½ Broad St., Rome
 Gilbert, Warren M., Harbin Clinic, Rome
 Hackett, Walter G., Harbin Clinic, Rome
 Harbin, B. Lester, Harbin Clinic, Rome
 Harbin, R. M., Jr., Harbin Clinic, Rome
 Harbin, Thomas S., Harbin Clinic, Rome
 Harbin, Wm. P., Jr., Harbin Clinic, Rome
 Jenkins, O. W., Lindale
 Johnson, Ralph N., McCall Hospital, Rome

Ketchum, Walter H., Battey Hospital, Rome
 Lewis, Wm. H., Floyd Hospital, Rome
 McCall, John T., Jr., McCall Hospital, Rome
 McCord, M. M., McCall Hospital, Rome
 McCord, Ralph B., McCall Hospital, Rome
 Moore, C. W. Cary, 409 St. Broad St., Rome
 Moore, Clifford, Lindale
 Moore, Clifford, Jr., 409 S. Broad, Rome
 Moss, T. H., 409 S. Broad St., Rome
 Mull, J. H., McCall Hospital, Rome
 Norton, John H., Jr., Cave Spring
 Norton, Robert F., 5 Cherokee St., Rome
 Orton, Sarah P., Battey State Hospital, Rome
 Payne, Rufus F., Battey State Hospital, Rome
 Pendley, Walter O., McCall Hospital, Rome
 Perkins, George E., II, Battey Hospital, Rome
 Rountledge, A. F., Barron Bldg., Rome
 Sapp, Clarence J., 200 E. Third St., Rome
 Sewell, W. A., 106 Charlton Road, Rome (Hon.)
 Smith, George B., Harbin Clinic, Rome
 Smith, Inman, First Nat'l. Bank Bldg., Rome
 Smith, Stephen D., 321 W. Seventh St., Rome
 *Starr, Harlan McKinney, 4005th U. S. Army Hospital, Ft. Hood, Tex.
 Whelchel, F. C., Battey State Hospital, Rome
 Wyatt, C. J., Jr., Harbin Clinic, Rome

FORSYTH COUNTY

Bramblett, Rupert H., Jr., Route 3, Cumming
 Mashburn, James S., Cumming
 Mashburn, Marcus, Cumming
 Mashburn, Marcus, Jr., Cumming

FRANKLIN COUNTY

Brown, S. D., Royston
 Brown, Stewart D., Jr., Royston
 Parker, G. M., Carnesville
 Poole, E. T., Lavonia
 Ridgway, Robert E., Royston
 Smith, B. T., Carnesville
 Williams, John Weldon, Jr., Lavonia

FULTON COUNTY

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 Abercrombie, T. F., Ga. Dept. of Public Health, Atlanta (Hon.)
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 Adams, Chas. R., 840 Gordon St., S. W., Atlanta
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Adams, H. M. S., Candler Bldg., Atlanta
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 Allgood, Pierce, 478 Peachtree St., N. E., Atlanta
 Allison, Gordon G., Grant Bldg., Atlanta
 Almand, Claude A., VA, 105 Pryor St., N. E., Atlanta
 Anderson, S. A., 3536 Roxboro Road, N. E., Atlanta
 Anderson, W. W., 478 Peachtree St., N. E., Atlanta
 Armstrong, T. B., 1404 North Ave., N. E., Atlanta (Hon.) (deceased)
 Armstrong, W. B., 490 Peachtree St., N. E., Atlanta
 Arnold, W. A., Peters Bldg., Atlanta
 Arp, C. Raymond, 478 Peachtree St., N. E., Atlanta
 Arteaga, Oliver, 152 Forrest Ave., N. E., Atlanta
 Arthur, J. F., 5 Forsyth St., N. W., Atlanta
 Askew, Rufus A., 10 Pryor St. Bldg., Atlanta
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 Ayer, Darrell, Jr., Crawford W. Mem. Long Hospital, Atlanta
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 Baggett, L. G., 478 Peachtree St., N. E., Atlanta
 Bailey, M. K., Medical Arts Bldg., Atlanta
 Baird, Jas. B., 62 28th St., N. W., Atlanta (Hon.)
 Baird, J. Mason, Medical Arts Bldg., Atlanta
 Baird, Noah W., 541 Lee St., S. W., Atlanta
 Baker, Luther P., 706 Peters Bldg., Atlanta (deceased)
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 Bateman, Needham B., Jr., Candler Bldg., Atlanta
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 Beasley, B. T., 701 Hurt Bldg., Atlanta
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 Berry, Maxwell R., Jr., 1010 W. Peachtree St., N. W., Atlanta
 Bishop, Everett L., Medical Arts Bldg., Atlanta
 Bivings, F. Lee, 20 Fourth St., N. W., Atlanta
 Bivings, Wm. Troy, 756 Cypress St., N. E., Atlanta (Hon.)
 Blackford, L. Minor, 104 Ponce de Leon Ave., N. W., Atlanta
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 Blalock, John C., Medical Arts Bldg., Atlanta
 Blalock, Tully T., 490 Peachtree St., N. E., Atlanta
 Blandford, W. C., Candler Bldg., Atlanta
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 Bloom, Walter L., Emory University Hospital, Emory University
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 Blumberg, Richard W., 33 Ponce de Leon Ave., N. E., Atlanta
 Blumenthal, Irvin, Medical Arts Bldg., Atlanta
 Boger, Richard E., 490 Peachtree St., N. E., Atlanta
 Boland, Chas. G., 157 Forrest Ave., N. E., Atlanta
 Boland, Frank K., 478 Peachtree St., N. E., Atlanta
 Boland, F. Kells, Jr., 478 Peachtree St., N. E., Atlanta

- Boland, Joseph H., 478 Peachtree St., N. E., Atlanta
- Boling, Edgar, 490 Peachtree St., N. E., Atlanta
- Bondurant, H. William, 478 Peachtree St., N. E., Atlanta
- Bondy, Philip K., Grady Mem. Hospital, Atlanta (Asso.)
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- Bove, Charles F., 1015 Candler Bldg., Atlanta
- Bowdoin, C. Dan, Ga. Dept. of Public Health, Atlanta
- Boyd, B. Hartwell, 56 Fifth St., N. E., Atlanta
- Boyd, Montague L., 563 Capitol Ave., S. W., Atlanta
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- *Brawley, Wm. Gaston, U. S. Army (Asso.)
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- Brawner, Darnell L., 513 Whitaker St., Savannah (Asso.)
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- Brown, Charles E., 21 Eighth St., N. E., Atlanta
- Brown, Joseph C., Conyers
- Brown, Lester A., 490 Peachtree St., N. E., Atlanta
- Brown, Robert H., 144 Ponce de Leon Ave., N. E., Atlanta
- Brown, Robert L., Emory University Hospital, Emory University
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- Brown, Samuel Y., 478 Peachtree St., N. E., Atlanta
- Brown, Stephen T., Medical Arts Bldg., Atlanta
- Bryan, Wm. W., 490 Peachtree St., N. E., Atlanta
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- Buesing, Oliver R., 16 Broad St., Williston Park, Long Island, N. Y. (Asso.)
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- Byram, James H., Grand Theatre Bldg., Atlanta
- Byrd, Edwin S., 1207 Oxford Rd., N. E., Atlanta (Hon.)
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- Calhoun, F. P., Jr., 478 Peachtree St., N. E., Atlanta
- Camp, R. T., Fairburn
- Campbell, John D., 490 Peachtree St., N. E., Atlanta
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- Carter, A. W., Jr., Forest Park
- Carter, Sandy B., Jr., 34 Seventh St., N. E., Atlanta
- Cason, Wm. M., 286 Lindbergh Drive, N. E., Atlanta
- Cathcart, Don F., 490 Peachtree St., N. E., Atlanta
- Catron, I. T., 16 Avondale Plaza, Avondale Estates (Hon.)
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- Chambers, Benjamin M., Grant Bldg., Atlanta
- Champion, W. L., 490 Peachtree St., N. E., Atlanta (Hon.)
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- Pruce, Maria, VA Regional Office, Atlanta (Asso.)
- Pruitt, Marion C., Medical Arts Bldg., Atlanta
- Quillian, G. W., Arlington, Va. (deceased)
- Quillian, W. Earl, Medical Arts Bldg., Atlanta
- Quinby, Griffith E., U. S. Public Health Service, Atlanta (Asso.)
- Ragan, W. E., Jr., 25 Third St., N. E., Atlanta
- Raiford, Morgan B., 144 Ponce de Leon Ave., N. E., Atlanta
- Rankin, Joseph L., Medical Arts Bldg., Atlanta
- Rankine, C. A. N., 3997 Peachtree Rd., Brookhaven
- Rapp, Edwin Wallace, VA Hospital, Augusta (Asso.)
- Rasmussen, Earl, Medical Arts Bldg., Atlanta
- Rauber, Albert P., 490 Peachtree St., N. E., Atlanta
- Rawiszer, Hubert, Candler Bldg., Atlanta
- Rayle, Albert A., 478 Peachtree St., N. E., Atlanta
- Rayle, Albert A., Jr., Emory University Hospital, Emory University
- Read, Ben S., Medical Arts Bldg., Atlanta
- Read, Joseph C., Medical Arts Bldg., Atlanta
- Redd, S. C., 645 Lee St., S. W., Atlanta
- Reed, Clinton, Candler Bldg., Atlanta
- Reed, John H., Jr., Grand Theatre Bldg., Atlanta
- Reider, Reuben F., U. S. Public Health Service, Chamblee (Asso.)
- Rhodes, C. A., 126 Forrest Ave., N. E., Atlanta
- Rice, Guy V., Ga. Dept. of Public Health, Atlanta
- Rice, Keith C., Medical Arts Bldg., Atlanta
- Richardson, Augustus C., Jr., Medical Arts Bldg., Atlanta
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- Ridley, John H., Medical Arts Bldg., Atlanta
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- Roseborough, Wm. Daniel, VA Hospital, Augusta (Asso.)
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- Rosenberg, Herbert J., 478 Peachtree St., N. E., Atlanta
- Ross, Ivan B., Ga. Baptist Hospital, Atlanta
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- Rumble, Lester, Jr., St. Joseph's Infirmary, Atlanta (Asso.)
- Rushin, C. E., 478 Peachtree St., N. E., Atlanta
- Russell, David A., Jr., Grand Theatre Bldg., Atlanta
- Sage, Dan Y., 47 Inman Circle, N. E., Atlanta
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- Sunderman, F. Wm., Jefferson Med. College, Philadelphia, Pa. (Asso.)
- Supan, Peter C., Healey Bldg., Atlanta (Asso.)
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- Thomason, W. L., 157 Forrest Ave., N. E., Atlanta
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- *Turner, Edwin W., Hunter Air Force Base, Savannah (Asso.)
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- Veatch, Jesse Wm., Jr., 490 Peachtree St., N. E., Atlanta
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- Walker, John Franklin, Lawson VA Hospital, Chamblee (Asso.)
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- West, Edward M., Candler Bldg., Atlanta
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- Whitaker, Wm. G., Jr., 490 Peachtree St., N. E., Atlanta
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- *Wikler, Irving, 64th Field Hospital, APO 59, San Francisco, Calif.
- Wilkins, Samuel A., Jr., Emory University Hospital, Emory University
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- Willingham, T. I., 56 Fifth St., N. E., Atlanta
- Willis, Augusta E., Charleston, S. C. (Asso.)
- Wilmer, John Grant, Medical Arts Bldg., Atlanta
- Wilson, Jos. S., Grady Mem. Hospital, Atlanta (Asso.)
- Winstead, George A., Grady Mem. Hospital, Atlanta (Asso.)
- Woddial, Jos. D., Forest Park
- Wolff, Bernard P., Medical Arts Bldg., Atlanta

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 Yarn, Charles P., Jr., Medical Arts Bldg., Atlanta
 York, Jesse H., Medical Arts Bldg., Atlanta

GLYNN COUNTY

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 Barker, Geo. Wm., Jr., St. Marys
 Brawner, L. E., Box 159, St. Simons Island
 Burford, Robert S., Gordon Bldg., Brunswick
 Coe, H. M., Gordon Bldg., Brunswick
 Collier, Thos. W., 706 Gloucester St., Brunswick
 Crichton, Robert B., St. Simons Island
 Galin, A. N., 509 F St., Brunswick
 Greer, C. B., 1127 Union St., Brunswick
 Hicks, Jas. M., 1614 Union St., Brunswick
 Johnston, Thomas H., 2117 Norwich St., Brunswick
 Kirckman, Herbert, 1616 Reynolds, Brunswick
 McDaniel, S. P., Andrews Bldg., Brunswick
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 Moore, Haywood L., Dunwody Bldg., Brunswick
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 Valente, Louis A., Darien
 Wilson, C. A., Jr., 801-3 Mansfield St., Brunswick
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GORDON COUNTY

Acree, M. A., Route 2, Calhoun
 Banks, Geo. T., Fairmount (Hon.)
 Billings, J. E., Calhoun
 Hall, W. D., Calhoun
 Lang, Lewis R., Calhoun
 Richards, Charles K., Calhoun
 Steele, Byron Harold, Fairmount
 Walter, R. D., Calhoun

GRADY COUNTY

Arline, T. J., Cairo (Hon.)
 Beale, George L., 14800 Bay Shore Dr., Maderia Beach, St. Petersburg, Fla.
 Hancock, Sidney Lanier, Cairo

Rehberg, A. W., Cairo
 Reynolds, A. B., Cairo
 Reynolds, H.M., Cairo (deceased)
 Rogers, J. V., Cairo
 Walker, W. A., Cairo (Hon.)
 Warnell, J. B., Cairo

GREENE COUNTY

Etheridge, Wm. M., Huntsville, Ala.
 Killam, F. H., Greensboro
 Parker, Lee, Greensboro

GWINNETT COUNTY

Cain, Sylvester, Norcross
 Chastain, Jos. Robert, Buford
 Hinton, Samuel Herbert Lawrenceville
 Hutchins, Harry, Buford
 Hutchins, W. J., Buford
 Kelley, D. C., Lawrenceville
 Mason, Miles Herbert, Duluth
 Puett, W. W., Norcross
 Sims, Fayette Alfred, Jr., Lawrenceville
 Smith, Reuben E., Buford

HABERSHAM COUNTY

Arrendale, Joe J., Cornelia
 Barrett, Clara, Ga. Dept. of Public Health, Atlanta
 Boyd, George Hugh, Jr., Clayton
 Brabson, T. H., Cornelia
 Candler, W. V., Baldwin (Hon.)
 Collins, Katherine R., Turnerville (Hon.)
 Garrison, D. H., Clarksville
 Hall, Irving Edward, Jr., Clayton
 Hardman, C. T., Tallulah Falls
 Henry, Chas. M., Clarksville
 Nicholson, George T., Cornelia
 Roberts, B. J., Cornelia
 Tolhurst, Geo. Monroe, Cleveland
 Walker, J. L., Clarksville

HALL COUNTY

Banks, Rafe, Jr., Gainesville
 Burns, J. K., Jr., Gainesville
 *Burns, J. K., III, Gainesville (Asso.)
 Butler, C. G., Gainesville
 Chandler, B. B., Gainesville
 Cheek, Pratt, Gainesville (Hon.)
 Davis, Bradley B., Gainesville
 Garner, W. Raleigh, Gainesville
 Gilbert, Benj. P., Gainesville
 Grove, E. W., Gainesville
 Hardman, Billy S., Gainesville
 Howard, Marcus, L., Dahlonega
 Hulsey, John M., Jr., New Holland
 Joiner, Hartwell, Gainesville
 Lancaster, H. H., New Holland
 McCarver, W. C., Jr., Gainesville
 McCrum, Barton A., Gainesville
 Meeks, Jesse L., Gainesville
 Nalley, Wm. Benjamin, Helen
 Neal, L. G., Cleveland
 *Neal, L. G., Jr., Naval Base, S. C.
 Rogers, R. L., Gainesville
 Sirmons, Derrell C., Dahlonega
 Smith, Martin Henry, Gainesville

Titshaw, H. S., Gainesville
 Valentine, H. E., Jr., Gainesville
 Ward, Eugene L., Gainesville
 Wheelchel, C. D., Gainesville
 Whitworth, C. W., Gainesville

HANCOCK COUNTY

Earl, H. L., Sparta
 Jernigan, C. S., Sparta
 Tanner, David E., Sparta

HART COUNTY

Cacchioli, Louis G., Hartwell
 Harper, G. T., Dewy Rose
 McCurry, W. E., Hartwell (Hon.)
 Milford, J. Hubert, Hartwell

HENRY COUNTY

Brandon, R. V., McDonough
 Ellis, H. C., McDonough (Hon.)
 Foster, G. R., Jr., McDonough

HOUSTON-PEACH COUNTIES

Hendrick, A. G., Perry
 Marshall, A. Smoak, Fort Valley
 Weems, H. E., Jr., Perry

JACKSON-BARROW COUNTIES

Allen, M. B., Hoschton
 Etheridge, Edwin Holt, Winder
 Harris, E. R., Winder
 Lord, C. B., Jefferson
 McDonald, E. M., Route 3, Winder
 Moore, Lewis Wm., Winder
 Pharr, L. P., Auburn (Hon.)
 Pittman, O. C., Commerce
 Randolph, W. Quentin, Winder
 Randolph, W. T., Winder
 Rogers, A. A., Commerce
 Rogers, A. A., Jr., Commerce
 Russell, Alexander B., Winder
 Scoggins, P. T., Commerce
 Stovall, J. T., Jefferson

JASPER COUNTY

Belcher, F. S., Monticello (Hon.)
 Fisher, Albert, Jr., Grady Mem. Hospital, Atlanta
 Lancaster, E. M., Shady Dale

JEFFERSON COUNTY

Bryant, V. L., Wadly
 Farris, John Jackson, Wadley
 Lewis, J. R., Louisville
 Pilcher, John J., Wrens
 Revell, Walter J., Louisville
 Pilcher, James W., Louisville
 Williams, Charles Roy, Wadley

JENKINS COUNTY

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 Fortney, A. P., Sylvania
 Lee, H. G., Millen
 Mulkey, A. P., Millen
 Mulkey, Q. A., Millen

LAMAR COUNTY

Corry, J. A., Barnesville
 Crawford, John B., Barnesville
 Jackson, J. H., Barnesville
 Prichett, D. W., Barnesville
 Traylor, S. B., Barnesville

*In Military Service.

LAURENS COUNTY

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 Avera, B. P., Jr., VA Hospital, Dublin (Asso.)
 Barton, J. J., Dublin (Hon.)
 Bell, John A., Jr., Dublin
 Bush, James L., Dublin
 Carter, J. G., Scott
 Cheek, O. H., Dublin
 Cheney, Fred D., VA Hospital, Dublin (Asso.)
 Claxton, E. B., Dublin
 Clayton, M. D., Dublin (Asso.)
 Cobb, Tyrus R., Jr., 107 Rowe St., Dublin
 Coleman, A. T., Dublin
 Coleman, Fred J., Dublin
 Coyle, Joseph A., VA Hospital, Dublin (Asso.)
 Dodd, Wm. Asa, Wrightsville
 Fernan-Nunez, M., VA Hospital, Dublin
 Hodges, C. A., Dublin
 Moye, C. G., Route 6, Dublin
 Mullins, Glenn, VA Hospital, Dublin (deceased)
 Quinn, David Edman, VA Hospital, Dublin (Asso.)
 Stapleton, James Wright, VA Hospital, Dublin
 Ware, A. D., Toombsboro

MACON COUNTY

Adams, J. Fred, Montezuma
 Adams, Thos. M., Montezuma
 Derrick, H. C., Oglethorpe
 Frederick, D. B., Marshallville (Hon.)

McDUFFIE COUNTY

Riley, B. F., Jr., Thomson

MERIWETHER-HARRIS COUNTIES

Allen, W. P., Woodbury
 Bennett, Robert L., Warm Springs
 Bennett, V. H., Gay
 Britt, Louis Percival, Ga. Warm Springs Foundation, Warm Springs
 Brown, Edward Ernest, Jr., Greenville
 Ellis, W. P., Chipley
 Gilbert, R. B., Greenville
 Gucker, Thomas, III, Ga. Warm Springs Foundation, Warm Springs
 Irwin, C. E., Warm Springs
 Jackson, Henry Calvin, Manchester
 Jackson, T. W., Manchester (Hon.)
 Johnson, J. A., Manchester
 Johnson, James A., Jr., Manchester
 Kirkland, W. P., Manchester
 Raper, Hal Stuart, Warm Springs Foundation, Warm Springs

MITCHELL COUNTY

Belcher, D. P., Pelham
 Brim, J. C., Pelham
 Crovatt, J. C., Camilla
 Gamble, Harold Scott, Camilla
 Harwell, C. W., Camilla
 Howard, C. L., Pelham

McNeill, Archibald Alexander, Jr., Camilla
 Pirkle, James C., Pelham
 Roles, C. L., Camilla
 Stevenson, C. A., Camilla (Hon.)
 Walker, Edwin Mercer, Pelham
 Williams, M. W., Camilla

MONROE COUNTY

Alexander, George H., Forsyth
 Bramblett, Augustus Walter, Jr., Forsyth
 Goolsby, R. C., Sr., Forsyth (Hon.)
 Hodges, Thomas L., Jr., Forsyth

MONTGOMERY COUNTY

Kusnitz, Morris, Jr., Alamo
 Palmer, J. W., Ailey

MORGAN COUNTY

Dickens, C. H., Madison
 McGeary, W. C., Madison
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 Porter, J. L., Rutledge (Hon.)
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MUSCOGEE COUNTY

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 Schley, Frank B., 303 Eleventh St., Columbus
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 Threatte, Bruce, 204 Eleventh St., Columbus

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 Willis, J. N., Swift Bldg., Columbus
 Winn, J. H., Columbus (deceased)
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 Wooldridge, J. C., Murrah Bldg., Columbus (Hon.)
 Youmans, J. R., Martin Bldg., Columbus (Hon.)

NEWTON COUNTY

Huson, W. Joseph, Covington
 Mitchell, J. B., Jr., Porterdale
 Nesbit, F. C., Covington
 Palmer, Clarence B., Covington
 Pierce, Edgar Harris, Covington
 Sams, J. R., 305 Church St., Covington
 Swann, W. K., Covington
 Waites, S. L., Covington
 Willson, Pleas, Newborn

OCMULGEE COUNTY (Bleckley-Dodge-Pulaski Counties)

Arnold, Maurice F., Hawkinsville
 Baker, Wm. R., Hawkinsville
 Batts, A. S., Hawkinsville
 Bush, Albert R., Hawkinsville
 Harp, S. L., Cochran
 Holder, Frank P., Jr., Eastman
 Jones, Edward G., Eastman
 Long, H. W., Eastman
 Massey, W. F., Chester
 Smith, J. M., Cochran (Hon.)
 Smith, Richard L., Cochran
 Thomson, James L., Eastman
 Whipple, R. L., Cochran

POLK COUNTY

Blanchard, Wm. H., Cedartown
 Chapman, W. A., Cedartown
 Chauldron, P. O., Cedartown
 Elliott, Cecil B., Cedartown
 Good, John W., Cedartown
 Griffith, J. E., Rockmart
 Lucas, W. H., Cedartown
 McBryde, T. E., Rockmart
 McGehee, John M., Cedartown
 Ross, Grace R., Cedartown
 Spanjer, Raymond F., Cedartown
 Styles, O. R., Cedartown
 White, George M., Rockmart

RABUN COUNTY

Dover, J. C., Clayton
 Neville, Lester, Dillard

RANDOLPH-TERRELL COUNTIES

Arnold, J. T., Parrott
 Daniel, Ernest F., Jr., Dawson

Elliott, W. G., Cuthbert
 Harper, T. F., Coleman
 Kenyon, J. M., Richland (Hon.)
 Kenyon, Steve P., Dawson
 Martin, F. M., Shellman
 Martin, Robert B., III, Cuthbert
 Martin, Walter D., Dawson
 Paschal, J. Dean, Albany
 Patterson, J. C., Cuthbert
 Pugh, C. Marion, Lumpkin
 Quattlebaum, Robert B., Ft. Gaines
 Rogers, F. S., Coleman
 Sims, A. R., Richland
 Tidmore, J. C., Dawson

RICHMOND COUNTY

Agee, M. P., 753 Broad St., Augusta
 *Agostas, Wm. N., C. S. Army (Asso.)
 Allen, L. H., Medical College of Ga., Augusta
 Bailey, Thomas E., 315 Tenth St., Augusta
 Barfield, Wm. E., 802 Russell St., Augusta
 Battey, W. W., 1445 Harper St., Augusta
 Bazemore, J. Malcolm, 3023 Pine Needle Rd., Augusta
 Beard, B. C., 739 Greene St., Augusta
 Bedingfield, W. R., Southern Finance Bldg., Augusta
 Bell, Jack E., 1242½ Greene St., Augusta
 Bernard G. T., 204 Thirteenth St., Augusta
 Bowen, J. B., 2505 Henry St., Augusta (Asso.)
 Boyd, Wm. S., 1920 Greene St., Augusta
 Brittingham, John W., 1345 Greene St., Augusta
 Brown, Stephen W., Sou. Finance Bldg., Augusta
 Brown, Thomas P., Route 5, Thomasville
 Bryans, C. I., 967 Meigs St., Augusta (Hon.)
 Burdshaw, Jas. F., 2571 Mt. Auburn Ave., Augusta (Hon.)
 Burdshaw, W. J., 718 Monte Sano Ave., Augusta
 Burdison, Wm. Ronald, VA Hospital, Augusta (Asso.)
 Carswell, Augustin S., Sou. Finance Bldg., Augusta
 Carter, Curtis H., 942 Greene St., Augusta
 Chaney, Ralph H., 1445 Harper St., Augusta
 Chandler, John L., Jr., University Hospital, Augusta
 Clary, Thomas L., Jr., 842 Greene St., Augusta
 Cleckley, Hervey M., University Hospital, Augusta
 Corbitt, Melvis O., 1309 Holden St., Augusta
 Cranston, W. J., 1345 Greene St., Augusta
 Davis, Abe J., 3039 Pine Needle Rd., Augusta

Davis, David A., University Hospital, Augusta
 DeVaughn, N. M., 124 Seventh St., Augusta
 Duncan, John A., P. I. Box 117, E. I. DuPont, Augusta
 Ellison, Robert G., 2321 King Way, Augusta
 Everett, Theodore, 1345 Greene St., Augusta
 Flanagan, W. S., University Hospital, Augusta
 Fuller, Wm. A., 1345 Greene St., Augusta
 Goodwin, Thomas W., Sou. Finance Bldg., Augusta
 Gray, J. D., 842 Greene St., Augusta
 Greenblatt, Robert B., Medical College of Ga., Augusta
 Hair, L. Quinby, 107 Macartan St., Augusta
 Hamilton, Wm. F., Jr., University Hospital, Augusta
 Harper, Harry T., Jr., Sou. Finance Bldg., Augusta
 Harrell, H. P., Sou. Finance Bldg., Augusta
 Harrison, F. N., 2733 Milledgeville Rd., Augusta
 Hearn, Henry B., III, University Hospital, Augusta (Asso.)
 Henry, C. G., 842 Greene St., Augusta
 Hensley, Ernest A., Gibson
 Hirsch, Jack W., VA Hospital, Augusta (Asso.)
 Hitchcock, J. P., 926 Telfair St., Augusta
 Hock, Charles W., Medical College of Georgia, Augusta
 Holmes, L. P., Sou. Finance Bldg., Augusta
 Hopkins, Enon C., Navy Recruiting Station, Macon (Asso.)
 Hummel, John E., Sou. Finance Bldg., Augusta
 Jennings, W. D., Marion Bldg., Augusta
 Johnson, Robert W., 1229 Greene St., Augusta
 Jones, G. Frank, Jr., 1020 Greene St., Augusta
 Kelly, G. Lombard, Medical College of Georgia, Augusta
 Kelly, Gordon M., 1445 Harper St., Augusta
 Kennedy, F. A., Bath, S. C.
 Kilpatrick, A. J., Forest Hills, Augusta (Hon.)
 Kilpatrick, C. M., Sou. Finance Bldg., Augusta
 Klemann, Gilbert L., Sou. Finance Bldg., Augusta
 Lacy, George R., Jr., Medical College of Georgia, Augusta
 Lee, F. Lansing, 301 Tenth St., Augusta
 Leonard, Robert E., 1109 Telfair St., Augusta
 Levy, Jack H., 1345 Greene St., Augusta
 Lewis, S. J., Sou. Finance Bldg., Augusta

*In Military Service.

*Lokey, Julian L., 491 Custer Terrace, Ft. Benning (Asso.)
 Luther, C. G., Jr., 926 Telfair St., Augusta
 *Major, Robert C., Fitzsimmons General Hospital, Denver Colo. (Asso.)
 Manganiello, Louis O. J., University Hospital, Augusta
 Martin, John M., 1445 Harper St., Augusta
 Massengale, Leonard R., 551 Greene St., Augusta
 Matthews, W. E., Sou. Finance Bldg., Augusta
 McGahee, R. C., 1345 Greene St., Augusta
 McGinty, Howard C., 1001 Hickman Rd., Augusta
 McInnes, George F., University Hospital, Augusta
 McRae, Donald R., Jr., 1345 Greene St., Augusta
 Mealing, H. G., Sou. Finance Bldg., Augusta
 Michel, H. M., 1229 Glenn Ave., Augusta (Hon.)
 Miller, Abraham, 1345 Greene St., Augusta
 Miller, John M., 842 Greene St., Augusta
 Milligan, King W., 942 Greene St., Augusta
 Mountain, G. W., 1121 Monte Sano Ave., Augusta (Hon.)
 Mulherin, Charles M., 1528 Gwinnett St., Augusta
 Mulherin, F. X., 1345 Greene St., Augusta
 Mulherin, Joseph L., 842 Greene St., Augusta
 Mulherin, Philip A., 1427 Harper St., Augusta
 Murphey, Eugene E., 432 Telfair St., Augusta (Hon.)
 New, James S., 1445 Harper St., Augusta
 Norvell, J. T., 1240 Greene St., Augusta
 O'Rear, Harry B., University Hospital, Augusta
 *Palmer, John R., Jr., U. S. Navy Station, Green Cove Springs, Fla. (Asso.)
 Pennington, Weems R., Lincolnton
 Perkins, H. R., Sou. Finance Bldg., Augusta
 Persall, John T., Jr., Sou. Finance Bldg., Augusta
 Philpot, W. K., 1345 Greene St., Augusta
 Phillips, Curtis M., Jr., Medical College of Georgia, Augusta
 Phinizy, Irvine, Sou. Finance Bldg., Augusta
 Pinson, Harry D., 842 Greene St., Augusta
 Price, W. T., Leonard Bldg., Augusta
 Pund, Edgar R., Medical College of Georgia, Augusta
 Reeves, Nathan, Sou. Finance Bldg., Augusta

Reeves, Ninette Payne, University Hospital, Augusta (Asso.)
 Rhodes, R. L., Sou. Finance Bldg., Augusta
 Rinker, J. Robert, University Hospital, Augusta
 Risteen, W. A., University Hospital, Augusta
 Roberts, W. H., 828 Greene St., Augusta
 Robertson, J. Righton, 1345 Greene St., Augusta
 Roule, J. Victor, Sou. Finance Bldg., Augusta
 Sanderson, E. S., Medical College of Georgia, Augusta
 Scharnitzky, E. O., 1262 Greene St., Augusta
 Sell, M. B., Jr., 926 Telfair St., Augusta
 Sheppard, Walter L., University Hospital, Augusta
 Sherman, John H., University Hospital, Augusta
 Steed, Wm. Alexander, 305 Tenth St., Augusta
 Sydenstricker, V. P., University Hospital, Augusta
 Templeton, C. M., Sou. Finance Bldg., Augusta
 Tessier, Claude E., Masonic Bldg., Augusta
 Thigpen, Corbitt H., University Hospital, Augusta
 Thomas, David R., Jr., Sou. Finance Bldg., Augusta
 Thoroughman, Jas. C., VA Hospital, Augusta
 Thurmond, A. G., 623 Greene St., Augusta
 Thurmond, J. W., 623 Greene St., Augusta
 Timmons, C. C., 415 Milledge Rd., Augusta
 Torpin, Richard, Medical College of Georgia, Augusta
 Volpitto, Perry P., University Hospital, Augusta
 Wall, Bithel, University Hospital, Augusta
 Wammock, Hoke, Medical College of Georgia, Augusta
 Wammock, Virgene S., 3012 Fox Spring Rd., Augusta
 Waters, A. Jack, University Hospital, Augusta
 Watson, W. G., 623 Greene St., Augusta
 Weeks, J. L., Harlem (Hon.)
 Weeks, R. B., Sou. Finance Bldg., Augusta
 White, Wm. O., 1345 Greene St., Augusta
 Wilcox, Everard A., P. O. Box 615, Beaufort, S. C. (Hon.)
 Wilkes, W. A., 1453 Harper St., Augusta
 Williams, David C., Jr., 1345 Greene St., Augusta
 Williams, W. J., Sou. Finance Bldg., Augusta
 Willis, C. H., Jr., Washington Rd., Augusta
 Wright, George W., 1345 Greene St., Augusta

Wright, Peter B., University Hospital, Augusta
 Wylie, M. H., Sou. Finance Bldg., Augusta
 Yates, T. M., 1113 Fairview Dr., Columbia, S. C.

ROCKDALE COUNTY

Griggs, H. E., Conyers

SCREVEN COUNTY

Freeman, James C., Sylvania
 Hawkins, Katrine Rawls, Sylvania
 Hogsette, Gerald B., Sylvania
 Lanier, L. Fielding, Sylvania
 Simmons, Wm. G., Sylvania

SOUTH GEORGIA MEDICAL SOCIETY

(Berrien-Clinch-Cook-Echols-Lanier and Lowndes Counties)

Austin, G. J., Jr., 101 W. Brookwood Drive, Valdosta
 Bird, Frank, Lake Park (Hon.)
 Burns, D. L., 313 E. Adair, Valdosta
 Campbell, James L., Jr., 103 W. Brookwood Dr., Valdosta
 Clements, Fred N., Adel
 Eldridge, F. G., 103 W. Brookwood Drive, Valdosta
 Gibson, Ira M., 101½ W. Brookwood Drive, Valdosta
 Giddens, C. C., 1303 N. Patterson St., Valdosta
 Giddens, I. S., Lakeland
 Hutchinson, L. R., Adel
 Johnson, A. M., 102 E. Central Ave., Valdosta
 Little, Alex G., Jr., 1306 N. Patterson St., Valdosta
 McKey, Earle S., Jr., 1306 N. Patterson St., Valdosta
 Mixson, E. Harry, 1306 N. Patterson St., Valdosta
 Mixson, J. F., 1306 N. Patterson St., Valdosta
 Mixson, Joyce F., Jr., 1306 N. Patterson St., Valdosta
 Oliphant, Jones B., Adel
 Owens, B. G., 1306 N. Patterson St., Valdosta
 Parrott, Jesse T., Hahira
 Perry, Robert E., Jr., 107 W. Jane St., Valdosta
 Peters, James S., Jr., Nashville
 Quillian, E. P., Clyattville (deceased)
 Robbins, Allen L., Homerville
 Saunders, A. F., 1306 N. Patterson St., Valdosta
 Schnauss, Wm. R., Adel
 Sherman, Henry T., 1310½ N. Patterson St., Valdosta
 Shipp, Larry G., New Orleans
 Smith, E. J., Hahira
 Smith, J. Gregg, Lowndes County Dept. of Health, Valdosta
 Smith, J. R., Hahira
 Smith, Tom H., 134½ N. Patterson St., Valdosta
 Stump, Robert L., Jr., 103 W. Brookwood Drive, Valdosta

Thomas, F. H., 130 W. Central Ave., Valdosta
 Thompson, E. F., 400 W. Central Ave., Valdosta
 Turner, J. D., Nashville
 Waugh, Wm. C., Nashville
 Williams, T. C., 105½ E. Central Valdosta

SPALDING COUNTY

Austin, J. L., Griffin
 Black, Grady E., Griffin
 Brown, George W., Griffin
 Clouse, John E., Jr., Griffin
 Copeland, H. J., Griffin
 Floyd, T. J., Jr., Griffin
 Frye, Augustus H., Jr., Griffin
 Giles, J. T., Griffin
 Hammond, Robert L., Jackson
 Head, D. L., Zebulon
 Head, M. M., Zebulon
 Hicks, Wright G., Jackson
 Hunt, Kenneth S., Griffin
 *Jones, Alex P., Fort Sam Houston, Texas
 King, Harry C., Griffin
 King, William R., Jr., Griffin
 Levine, Herbert J., Box 198, Centralia, Ill.
 Oshlag, Abraham M., Griffin
 Smaha, T. G., Griffin
 Stuckey, Ann, Griffin
 Venable, John H., Griffin
 Walker, George L., Griffin
 Watkins, James Wm., Jr., Jackson

STEEPHENS COUNTY

Ayers, C. L., Toccoa
 Chaffin, E. F., Toccoa
 Cleveland, Parish B., Toccoa
 Edge, J. H., 356 Home Park Ave., N. W., Atlanta (Hon.)
 Good, Wm. H., Jr., Toccoa
 Heller, W. B., Lakemont (Hon.)
 Isbell, J. E. D., Toccoa
 McNeely, H. H., Toccoa
 Schaefer, W. Bruce, Toccoa
 Shiflet, Robert E., Toccoa
 Singer, Arthur G., Toccoa

SUMTER COUNTY

Boyette, L. S., Ellaville
 Cheves, Landgon C., Jr., Montezuma
 Collins, Robert A., Jr., Montezuma
 Durham, Bon M., Americus
 Fenn, Henry R., Americus
 Gatewood, T. Schley, Americus
 Logan, J. Colquitt, Plains
 McMath, Wm. B., Americus
 Moorman, John H., Jr., Americus
 Pendergrass, Robert C., Americus
 Primrose, A. C., Americus
 Robinson, John H., III, Americus
 Savage, C. P., Montezuma
 Seay, E. Faxton, Marshallville
 Smith, Herschel A., Americus
 Thomas, Russell B., Americus
 Wilson, Frank A., III, Leslie
 *Wise, B. Thad, Americus
 Wise, Samuel P., II, Americus
 Wood, Kenneth, Leslie

TATTNALL COUNTY

Collins, J. C., Collins
 Colson, A. C., Glennville
 Hughes, J. M., Glennville
 Jelks, L. R., Reidsville
 Pinkston, A. G., Jr., Glennville
 Strickland, L. V., Cobbtown

TAYLOR COUNTY

Beason, Lewis, Butler
 Montgomery, R. C., Butler
 Montgomery, Robert C., II, Butler
 Sams, F. H., Reynolds
 Whatley, E. C., Reynolds

TELFAIR COUNTY

Born, W. H., McRae
 Harrell, Augustus O., Milan (Hon.)
 Jones, A. J., Jacksonville (Hon.)
 Maloy, C. J., McRae
 Maloy, D. W., Milan (Hon.) (deceased)
 Mann, F. R., McRae
 Mann, Frank R., Jr., McRae
 Parkerson, S. T., McRae
 Smith, F. A., Jr., McRae

THOMAS COUNTY

Baldwin, Marion A., Thomasville
 Bell, Rudolph, Thomasville
 Bellhouse, Helen W., 12 Capitol Sq., S. W., Atlanta
 Cheshire, Howard L., Thomasville
 Collins, J. J., Thomasville
 Daniel, Frank C., Pavo
 Dillinger, George R., Thomasville
 Erickson, Mary J., Thomasville
 Friddell, William F., Boston (Hon.)
 Futch, T. Allen, Jr., Thomasville
 Isler, J. N., Meigs (Hon.)
 Jones, Henry, Coolidge (Hon.)
 King, J. T., Thomasville
 Levy, Tracy, USPH Outpatient Clinic, 4th and D St., S. W., Washington, D. C.
 Little, Frank A., Thomasville
 Lundy, L. L., Boston
 McCollum, William, Thomasville
 Mobley, J. W., Thomasville
 Moore, H. M., Thomasville
 Morton, John B., Thomasville
 Murphy, Fred T., Thomasville
 Palmer, J. I., Thomasville
 Pepin, Henry S., Jr., Thomasville
 Readling, Herbert, Thomasville
 Reid, James W., Thomasville
 Sanchez, S. E., Jr., Barwick
 Saye, E. B., Thomasville
 Shepard, Kirk, Thomasville
 Stillwell, J. D., Thomasville
 Stinson, Roy F., Thomasville
 Wahl, Ernest F., Thomasville
 Wall, C. K., Thomasville
 Wasden, Howell A., Jr., Pavo
 Watt, C. H., Thomasville
 Wine, Mervin B., Thomasville

TIFT COUNTY

Andrews, Agnew, Tifton
 Andrews, Ella F., Tifton
 Edmondson, Tom L., Tifton
 Evans, E. L., Tifton
 Flowers, Eugene M., Tifton
 Harrell, D. B., Tifton
 Jones, Robert E., Tifton
 Lucas, Paul W., Tifton

Pittman, Carl S., Tifton
 Pittman, C. S., Jr., Tifton
 Winston, Richard K., Tifton
 Zimmerman, Charles E., Tifton
 Zimmerman, W. F., Tifton

TOOMBS COUNTY

Aiken, W. W., Lyons
 Bedingfield, W. H., Vidalia
 *Conner, Herbert I., Vidalia
 Darby, V. Lee, Vidalia
 DeJarnette, R. H., Vidalia
 Findley, C. W., Vidalia
 Gross, O. S., Vidalia
 McArthur, J. D., Lyons
 Mercer, J. E., Vidalia
 Youmans, H. D., Lyons

TRI-COUNTY (Calhoun-Early-Miller Counties)

Baxley, W. C., Blakely
 Beard, J. S., Edison
 Bridges, R. R., Leary
 Crowdis, James H., Jr., Blakely
 Hays, W. C., Colquitt
 Holland, S. P., Blakely
 Lamson, Thomas H., Arlington
 Martin, James B., Edison
 Merritt, Hinton J., Colquitt
 Merritt, James W., Jr., Colquitt
 Rentz, Turner W., Colquitt
 Sharp, C. K., Arlington
 Shepard, W. O., Bluffton
 Standifer, J. G., Blakely
 Wall, W. H., Blakely

TRI-COUNTY (Liberty-Long-McIntosh Counties)

Armistead, I. G., Townsend
 Middleton, O. D., Ludowici

TROUP COUNTY

Arnold, E. T., Jr., Hogansville
 Avery, R. M., 206 Church St., LeGrange
 *Avery, William Greene, I-1736255, 8055th Mobile Surgical Hospital, AJO 301, c/o Postmaster, San Francisco, Calif.
 Calhoun, Samuel J., Langdale, Ala.
 Callaway, Enoch, 301 Church St., LaGrange
 Caswell, Doyle F., Franklin
 Chambers, J. W., 304 Church St., LaGrange
 Clark, W. H., 304 Church St., LaGrange
 Cowart, Charles T., 301 Broome St., LaGrange
 Easley, Curran S., Jr., 301 Broome St., LaGrange
 Fackler, William B., Jr., 110 Saynor Circle, LaGrange
 Freeman, Thos. N., Jr., 33 S. Court Square, LaGrange
 Grace, Kenneth D., 304 Church St., LaGrange
 Grady, Henry W., 304 Church St., LaGrange
 Hadaway, W. H., 200 Church St., LaGrange

*In Military Service.

Hammett, H. H., Hammett Bldg., LaGrange
 Hammett, H. H., Jr., Hammett Bldg., LaGrange
 Hand, B. Hollis, 301 Church St., LaGrange
 Harvey, C. W., Hoagsville
 Hendricks, Willis M., 304 Church St., LaGrange
 Herault, Pierre C., Jr., 109 Westwood Drive, LaGrange
 Herman, E. C., 107 Broad, LaGrange
 Holder, J. S., 304 Church St., LaGrange
 Hutchinson, Wm. L., 109 Broad, LaGrange
 Jones, H. T., West Point
 Lewis, James W., 301 Broome St., LaGrange
 McCall, W. R., 409 Hill St., LaGrange
 Mitchell, John T., City-County Hospital, LaGrange
 Molyneaux, Evan W., Hogansville
 Morgan, D. E., 618 Broad St., LaGrange (Hon.)
 Morgan, J. C., West Point
 Morgan, J. C., Jr., West Point (Asso.)
 Norman, Lewis G., Jr., West Point
 O'Neal, R. S., 116 Church St., LaGrange
 Park, Emory R., 103 Broad, LaGrange
 Phillips, W. Parks, 115 Church St., LaGrange
 Prescott, Eustace H., Dept. of Health, LaGrange
 Taylor, John L., Franklin
 Turner, J. R., Grady Mem. Hospital, Atlanta (Asso.)
 Whitehead, C. Mark, 304 Church St., LaGrange
 Williams, C. O., West Point

TURNER COUNTY

Baxter, J. H., Auburn (Hon.)

UPSON COUNTY

Barron, H. A., Thomaston (Hon.)
 Blackburn, John D., Thomaston
 Bridges, B. L., Thomaston
 Carter, R. L., Thomaston
 Dallas, R. E., Thomaston
 Garner, J. E., Thomaston
 Girardeau, Ivylyn, Thomaston
 Gower, Wm. J., Jr., Thomaston
 Grubbs, J. H., Molena
 Harris, C. A., The Rock
 Head, Douglas L., Jr., Thomaston
 Jordan, Thomas C., Jr., Thomaston
 Kellum, J. M., Thomaston
 McKenzie, J. M., Thomaston
 Mincey, R. J., Jr., Thomaston
 Sappington, T. A., Thomastno
 Tyler, Herbert D., Thomaston
 Woodall, Frank M., Thomaston
 Woodall, James A., Thomaston
 Woodall, Wm. P., Thomaston

WALKER-CATOOSA-DADE COUNTIES

Alexander, L. LeBron, Rossville
 Alsobrook, Thomas W., Rossville
 Cochran, T. A., Ringgold
 Cornett, Dennis M., LaFayette
 Derrick, Howard C., Jr., LaFayette
 Harner, Albanus A., III, Wildwood
 Hoover, John P., Rossville
 Kitchens, S. B., LaFayette
 Middleton, D. S., Rising Fawn (Hon.)
 O'Conner, Frank L., Rossville
 Pope, Roy, Jr., Chickamauga
 Pruitt, Maurice C., 2209 Rossville Blvd., Chattanooga, Tenn.
 Shepard, Richard C., LaFayette
 Shields, H. F., Chickamauga
 Simonton, Fred H., Chickamauga
 Stephenson, Chas. W., Ringgold
 Townsend, Egbert M., Ringgold (Hon.)
 Vassey, G. C., Rossville
 Wheeler, Stanley D., Wildwood

WALTON COUNTY

Anderson, M. W., Social Circle
 DeFreese, Samuel J., Monroe
 Floyd, Charles S., Loganville
 Head, Homer, Monroe
 Huie, Lynn M., Monroe
 Nunnally, Harry B., Monroe
 Stewart, Philip R., Monroe
 Thompson, Ernest, Monroe

WARE COUNTY

Adkins, H. T., 2007 Cherokee Drive, Waycross
 Andrews, Samuel E., S.A.L. Hospital, Waycross
 Bates, W. B., Jr., 802 Elizabeth St., Waycross
 Bradley, D. M., 629 Nichols St., Waycross
 Russell, B. R., Bunn Bldg., Waycross
 Calhoun, W. C., Satilla Blvd., Waycross
 Clayton, Malcolm D., Jr., VA Hospital, Dublin
 Collins, Braswell E., 701 Elizabeth St., Waycross
 Davis, Floyd, 201 Remshart St., Waycross
 DeLoach, A. W., 415 Remshart St., Waycross
 Ferrell, T. J., 202 Fokes St., Waycross
 Flanagan, W. M., 909 Carswell St., Waycross
 Fleming, A. Folkston
 Gay, Joseph R., Waycross (deceased)
 Goldman, Benj., Hazlehurst
 Goldwasser, Fred I., Alma
 Hawkins, L. M., Blackshear
 Henry, G. T., Blackshear
 Hendry, Katherine M., Blackshear
 Hendry, Wm. A., Blackshear
 Inman, Wm. O., Jr., Churchwell Apt., Waycross
 Jackson, Joseph M., Folkston
 Johnson, R. L., 509 Nichols St., Waycross (Hon.)

Knight, A. M., Jr., 301 Gilmore St., Waycross
 Lee, Walter E., Jr., 415 Remshart St., Waycross
 Massey, Clayton M., Bunn Bldg., Waycross
 Mauldin, John W., Alma
 McCollum, R. Roy, Jr., Kingsland
 McCoy, W. R., Folkston
 Minchew, B. H., 701 Elizabeth St., Waycross
 Mixson, W. D., 617 Nichols St., Waycross (Hon.)
 Muecke, H. W., 204 Folks St., Waycross
 Oden, John W., Blackshear (Hon.)
 *Oden, Lewis H., Jr., Tyndall Field, Panama City, Fla. (Asso.)
 Oden, T. E., Blackshear
 Parker, Charles L., Jr., 5624 Greentree Rd., Bethesda, Md. (Asso.)
 Penland, J. E., 912 Elizabeth St., Waycross
 Pierce, Lovick W., 513 Elizabeth St., Waycross
 Pomeroy, W. L., 901 Jane St., Waycross
 Reavis, W. F., 513 Elizabeth St., Waycross
 Schneider, W. J., Folkston
 Seaman, H. A., 701 Brunel St., Waycross
 Sharpe, W. W., III, Alma
 Shuman, Vilda, Bunn Bldg., Waycross
 Smith, Clyde, Jefferson-Hillman Hospital, Birmingham, Ala. (Asso.)
 Smith, Leo, 901 Jane St., Waycross
 Smith, William, Jr., John Gaston Hospital, Memphis, Tenn. (Asso.)
 Stephens, John A., Ware County Hospital, Waycross (Asso.)
 Terry, D. B., Homerville
 Trulock, Albert S., Jr., VA Hospital, Bay Pines, Fla.
 Youmans, C. R., Hazlehurst

WARREN COUNTY

Cason, H. B., Warrenton
 Davis, A. W., Warrenton

WASHINGTON COUNTY

Dillard, J. B., Davisboro (Hon.)
 Helton, B. L., Sanderville
 Hurt, M. W., Sandersville
 King, W. R., Tennille (Hon.)
 Lennard, O. D., Sandersville
 Lever, Joseph E., Sandersville
 McElreath, Farris T., Jr., Tennille
 Newsom, N. J., Sandersville
 Newsome, Emory G., Sandersville
 Overby, N., Sandersville
 Rawlings, William, Sandersville
 Rogers, O. L., Sandersville (Hon.)
 Taylor, Ralph L., Davisboro

WAYNE COUNTY

Harper, Fred M., Jesup
 Leaphart, E. C., Jesup
 Leaphart, J. A., Jesup
 Pumpelly, Robert A., Jr., Jesup
 Tyre, J. Lawton, Screven
 Yeomans, James W., Jesup
 Yeomans, Una Ritch, Jesup

*In Military Service.

WHITFIELD COUNTY

Ault, H. J., Dalton (Hon.) (deceased)
 Boozer, Albert M., Dalton
 Bradford, J. E., Spring Place
 Bradley, Paul L., Dalton
 Bradley, R. H., Chatsworth
 Broaddrick, G. L., Dalton
 *Carson, Willard P., Fort Sam Houston, San Antonio, Texas
 Dickie, E. H., Chatsworth (Hon.) (deceased)
 Erwin, H. L., Dalton (Hon.)
 King, Hubert C., Dalton
 Mullins, James N., Chatsworth
 Ragland, Fred B., Dalton
 Rollins, J. C., 1211 W. Rugby, College Park (Hon.)
 Rosen, E. A., Dalton
 Sams, Henry L., Dalton
 Starr, Trammell, Dalton

Whitfield, Truman W., Dalton
 Whitley, Jas. R., Dalton
 Wood, D. Lloyd, Dalton
 Wood, Jay G., Vinings

WILCOX COUNTY

Bussell, J. A., Rochelle (Hon.)
 Dorsey, Homer A., Pitts (Hon.)
 Durham, Wm. P., Abbeville
 Estes, J. M., Abbeville
 Harris, V. L., Rochelle (Hon.)
 Owens, J. D., Rochelle

WILKES COUNTY

Adair, M. C., Washington
 Cheves, H. L., Union Point
 Duggan, A. D., Washington
 Gibson, Frank N., Thomson
 Harriss, H. T., Washington (Hon.)

LeRoy, Albert G., Thomson
 Middlebrooks, T. W., Union Point
 Nash, T. C., Philomath
 Simpson, A. W., Washington (Hon.)
 Simpson, A. W., Jr., Washington
 Smith, R. H., Lincolnton
 *Sims, Lewis S., Jr., U. S. Navy, Jacksonville, Fla. (Asso.)
 Stephens, R. G., Washington
 Wills, C. E., Washington
 Wills, C. E., Jr., Washington
 Wood, O. S., Washington

WORTH COUNTY

Bell, Peyton E., Sylvester (Hon.)
 Crowe, Norman Jr., Sylvester
 Davis, H. G., Jr., Sylvester
 Jefford, T. C., Sylvester (Hon.)
 Stoner, W. P., Sylvester
 Sumner, Gordon S., Sylvester
 Tracy, J. L., Jr., Sylvester

*In Military Service.

GEORGIA PRESS**The March of Medical Science**

Let those who yearn for the "good old days" consider whether they'd be willing to accept the aches and pains and the shortened life span which went with them. A glance at the week's news calendar graphically reveals the progress of medical science.

On Sunday, the Southern Medical Association met in Dallas, Texas to hear reports on new wonder drugs, personality surgery and other modern miraculous techniques. On Monday, the American College of Surgeons, meeting in San Francisco, heard described the technique of borrowing another heart to keep a man alive while the sick person's heart was being repaired. On the same day, the National Academy of Science convened in New Haven, Conn. to consider how your brain learns and forgets and to study the latest advances in treatment of cancer and polio.

On Tuesday, the U. S. Air Force School of Aviation Medicine sponsored a meeting in San Antonio, Texas, devoted to discussions on what happens to flyers in space where there's neither air nor gravitation. And, tomorrow, the Electron Microscope Society meets in Philadelphia to tell what the super-eye sees at magnifications of one hundred thousand diameters of your nerves, teeth and blood.

The good old days? Maybe they were fine but they weren't nearly as healthy.

—*Macon News*

Billy Fort's Death Heavy Loss

Stricken down at an age before most men can said to have reached the prime of life, the death of William Albright Fort deprives Columbus and Georgia of one of its outstanding citizens.

Only 31 years old at the time of his passing,

Billy Fort already had demonstrated the qualities which would have taken him to the pinnacle of success. In his short span of years he had achieved wide recognition for his many acts of unselfish public service.

The Georgia Junior Chamber of Commerce earlier this year presented him with its distinctive service award, primarily in recognition of the work he had done in the March of Dimes campaign and as chairman of the City Hospital Board of Managers.

In this latter capacity, Billy Fort deserves a lion's share of the credit for City Hospital's advancement from a demoralized institution to one of the most progressive in the nation today. Only a few months ago the hospital regained its accreditation by the American Medical Association. Other achievements include establishment of a cardiac clinic, construction of a new laundry and approval for a new home for Negro student nurses. He recently appeared before City Commission to voice an appeal for more than a million dollars to continue the improvement program . . .

—*Columbus Ledger-Enquirer*

Insanity Results From Environment

Dr. Robert Carroll, State Department of Public Health, addressed the Rotary Club recently and spoke on mental health.

Dr. Carroll said there were 10,810 inmates at the Milledgeville State Hospital in July and the ever-increasing stream of patients could be slackened if everyone realized that mental health is an individual problem instead of a group problem.

He urged a revival of the old family councils, greater understanding of children and encouragement to distressed persons.

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WOMAN'S AUXILIARY

Mrs. Luther Wolff, of Columbus, was installed as manager of the Woman's Auxiliary to the Third District Medical Society at its annual fall meeting at the Columbus Country Club on November 15. Mrs. Dave Berman, Columbus, was installed as secretary, and Mrs. William McMath, Americus, was chosen manager-elect.

Mrs. Frank Schley, Columbus, was chairman of the nominating committee, and Mrs. Schley Gatewood, Americus, installed the new officers. The outgoing manager, Mrs. Alphonso R. Sims, Richland, presided at the meeting. Mrs. W. F. Jenkins, president of the Woman's Auxiliary to the Mucogee County Medical Society, welcomed the guests, with Mrs. Bon M. Durham, Americus, giving the response.

Mrs. Lester Harbin, president of the Floyd County Medical Society Woman's Auxiliary, at the conclusion of a luncheon on October 31 at General Forrest Hotel, Rome, named standing committees for the year. This was the first meeting of the Auxiliary since last spring. Before Mrs. Harbin announced the committees Mrs. C. Jackson Wyatt, secretary, made her report, and Mrs. Walter Pendley, treasurer, announced funds on hand.

Committee chairmen were given as follows: Mrs. Emmett Brannon, publicity; Mrs. Ralph J. Davis, membership; Mrs. Robert Harbin Jr., social; Mrs. Tom Harbin, public relations; Mrs. Frank Blalock, Today's Health; Mrs. Walter G. Hackett, Doctor's Day; Mrs. George Smith, legislative; Mrs. Warren Gilbert, research and romance of medicine.

"What Price Medical Care?" was the topic discussed at a forum presented by the Woman's Auxiliary to the Fulton County Medical Society at its annual health education meeting on November 2 at the Academy of Medicine, Atlanta.

The purpose of the yearly health education meeting is to bring to the community information of medical progress which may be applied to community interest and improvement. This year,

the discussion concerned the cost of medical care, and where, by whom and at what price, low-cost medical care may be obtained.

Speakers included: Frank Wilson, superintendent of Grady Hospital; A. P. Jarrell, director of vocational rehabilitation for the State Department of Education; Dr. W. J. Murphy, director of the Division of Cancer Control, Georgia Department of Public Health; Sid Wrightsman, Jr., director of public relations of the Medical Association of Georgia; and Edwin Peel, of Georgia Baptist Hospital. Dr. A. Hamblin Letton was moderator.

Exhibits by various health organizations and agencies were shown.

LEGION SURVEYS HEALTH RESOURCES

The National Rehabilitation Commission of the American Legion is currently conducting a national survey of "hospital beds for veterans and health resources." Basic studies for this survey have already been completed in several states and Legion representatives are now busy collecting pertinent facts and figures throughout the country.

The national survey was undertaken in accord with a resolution passed by the Legion in November, 1950. It called for a survey of "facts and figures on veterans' hospitalization needs, additional hospital beds, medical manpower shortage and medical teaching institutions throughout the country."

The resolution also stated that "The American Legion strongly advocates that medical schools of this country produce more doctors without sacrifice of quality; expansion within the existing schools of medicine to maximum capacity compatible to efficiency; expansion of courses to four years wherever possible, and creation of new medical schools sponsored by colleges or universities where needed and where proper support is assured."

A sizable contribution to the A.M.A. Education Fund by the American Legion would greatly assist accomplishment of this program.

General Interest

CALENDAR OF MEETINGS

SOUTHERN SECTION OF AMERICAN LARYNGOLOGICAL AND OTOLOGICAL SOCIETY, INC., Academy of Medicine, Atlanta, January 14, 9:30 a. m. Dr. Lester A. Brown, Atlanta, Vice-President.

GEORGIA COMMISSION ON CHRONIC ALCOHOLISM SYMPOSIUM, Taft Hall, City Auditorium, Atlanta, January 18, 7:30 p. m.

THE ATLANTIC COAST LINE RAILROAD SURGEONS ASSOCIATION, Fort Sumter Hotel, Charleston, S. C., January 24-25, 1952.

DISTRICT AND COUNTY SOCIETIES

The THIRD DISTRICT MEDICAL SOCIETY held its semi-annual meeting at Columbus on November 15, with Muscogee County Medical Society as host. The following scientific program was presented: "Amebiasis," Dr. John E. Walker, Columbus; "Pelvic Endometriosis," Dr. Walter R. Holmes, Atlanta; "Clinical Diagnosis of Congenital Heart Disease," Dr. Simone Brocato, Columbus, and "Prolapse of Gastric Mucosa in Relation to Other Gastrointestinal Lesions," Dr. George Hutto, Columbus.

At the conclusion of the scientific program Mr. Sid Wrightsman, Jr., executive secretary of the Medical Association of Georgia, Atlanta, spoke on aspects of medical public relations and outlined the five-point plan in regard to the State Mental Hospital at Milledgeville as set forth in the September issue of *The Journal*. By motion, the five-point program was unanimously endorsed and accepted.

The following officers for 1952 were elected: Dr. Frank Schley, Columbus, president; Dr. Walter Martin, Dawson, vice president, and Dr. Schley Gatewood, Americus, secretary-treasurer.

The Woman's Auxiliary to the Third District Medical Society met simultaneously at Columbus Country Club, where members and wives were entertained with a social hour and dinner following the meetings.

The FOURTH DISTRICT MEDICAL SOCIETY held its quarterly meeting on December 11 at the Newnan Country Club. The guest speaker was Dr. Vernon E. Powell, Atlanta, who spoke on "Office Management of Arthritis."

The EIGHTH DISTRICT MEDICAL SOCIETY met on October 6 and 7 at the King and Prince Hotel, St. Simons, with Dr. J. B. Avera, Brunswick, presiding. On the evening of Saturday, the 6th, there were a shore dinner and a dance. The following day a business session was held.

Papers were given by: Dr. J. Gregg Smith, Valdosta, "Public Health in Georgia"; Dr. J. L. Parrott, Hahira, "Treatment of Rattlesnake Bites"; Dr. A. P. Ohlmacher, Baxley, "Recent Advances in Repair of Abdominal Defects"; Dr. T. J. Ferrell, Waycross, "Typhoid Diseases"; Dr. T. H. Johnston, Brunswick, "Psychiatry in Practice," and Dr. J. Elliott Scarborough, Emory University, "Cancer in Everyday Practice."

Discussions were led by: Drs. M. E. Winchester, Brunswick; R. E. Perry, Valdosta; Fred Smith, McRae; H. A. Seaman, Waycross, and H. L. Moore, Brunswick.

The GEORGIA MEDICAL SOCIETY met in Savannah's Medical Society Hall on November 13 and heard a lecture on "Celiac Disease" by Dr. R. L. Schley, Jr.

The FULTON COUNTY MEDICAL SOCIETY met at the Academy of Medicine on November 1 for a dinner which was followed by a public panel discussion of heart disease. Moderator for the panel was Dr. E. A. Bancker. Questions were asked on the subject of heart disease by laymen, led by Oby T. Brewer, Herbert King and Ernest Rogers. Answers to the questions were given by Drs. L. Minor Blackford, Joseph C. Massee and J. Gordon Barrow.

The MUSCOGEE COUNTY MEDICAL SOCIETY met at the Columbus Country Club on October 23 and elected as its officers for the next year: Dr. E. K. Munn, president; Dr. George Hutto, vice-president, and Dr. E. J. Cain, secretary. Principal speaker was Dr. Gardner Riley, Ann Arbor, of the staff of the University of Michigan Medical School, who discussed the problem of sterility in married couples. Dr. Riley addressed the staff of Columbus' City Hospital the following evening on technics in the diagnosis of cancer.

The WARE COUNTY MEDICAL SOCIETY met on November 1 at the Community Club, Blackshear, with Dr. William A. Hendry, past-president of the society, presiding in the absence of the president, Dr. W. C. Calhoun. The group heard a report on the Georgia State Medical Press and Radio Conference given by Dr. Braswell E. Collins, public relations officer of the Ware County Society.

Resolutions were adopted lamenting the deaths of Drs. Joseph G. Ray and Raymond L. Johnson. They were prepared by Drs. B. H. Minchew, W. Loomis Pomeroy and W. F. Reavis. Hosts for the meeting were Drs. William A. Hendry, Katherine Hendry, G. T. Hendry, Thomas Oden and Lewis Hawkins.

The FIFTH DISTRICT MEDICAL SOCIETY met at the Academy of Medicine, Atlanta, on November 15 and elected as its new officers Dr. L. Minor Blackford, president; Dr. Cyrus W. Strickler, Jr., vice president, and Dr. C. Purcell Roberts, secretary-treasurer. All are Atlantans. Dinner was served prior to the meeting by the Woman's Auxiliaries of the Fifth District and Fulton County Medical Societies. The next meeting of the district group will be held in the spring.

The clinical program consisted of addresses by two members of the faculty of Bowman Gray School of Medicine, Winston-Salem, N. C., on the subject of older patients. Dr. Wingate M. Johnson, professor of medicine, spoke on "The Medical Care of Older Patients" and Dr. H. H. Bradshaw, professor of surgery, on "Surgery in Older Patients."

ANNOUNCEMENTS

The SOUTHERN SECTION OF THE AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, INC., will hold a one-day meeting at the Academy of Medicine in Atlanta on January 14, from 9:30 a. m. to 4:30 p. m. All members of the medical profession are invited to this meeting. There is no registration fee.

Seven speakers, each pre-eminent in his field, will deliver addresses. The men, their subjects and the times they are scheduled to speak are as follows:

Dr. John E. Bordley, Baltimore, Md., "The Problem of the Preschool Deaf Child—The Otologist's Role in Diagnosing His Deafness and Supervising His Rehabilitation," 11:15 a. m.; Dr. Samuel L. Fox, Baltimore, "Bleeding Following Tonsillectomy," 4 p. m.; Dr. V. K. Hart and Dr. William R. Pitts (neurosurgeon, by invitation), both of Charlotte, N. C., "The Diagnosis and Treatment of Acute Subdural Abscess Secondary to Frontal Sinusitis," 3:15 p. m.

Dr. Julian W. McCall, Cleveland, Ohio, "Cancer of the Larynx," 9:50 a. m.; Dr. Harry Rosenwasser, New York City, "Glomus Jugularis Tumor" (he is the author of the first clinical article on this subject), 10:30 a. m.; Dr. Joseph A. Sullivan, Toronto, Canada, "Recent Advances in the Treatment of Facial Paralysis and Bell's Palsy," 2:15 p. m.

THE ATLANTIC COAST LINE RAILROAD SURGEONS ASSOCIATION will hold its 48th Annual Meeting at the Fort Sumter Hotel, Charleston, South Carolina, January 24-25, 1952. Visiting physicians are welcome and there is no registration fee. Among the speakers will be: Dr. Joseph S. Stewart, Miami, President Southeastern Surgical Congress; Dr. Samuel F. Marshall, Boston, Lahey Clinic; Dr. Elam C. Toone, Richmond, Va., Medical

College of Virginia; Dr. J. S. Lyerly, Neurosurgeon, Jacksonville; Dr. John M. Harry, Chief of Surgical Staff Highsmith Hospital, Fayetteville, N. C. It is recommended that you make your reservations directly with the Hotel."

PROFESSIONAL GROUPS

Sixty-six Georgia physicians were registered at the forty-fifth annual session of the Southern Medical Association, Dallas, November 5-8, and included the following: Drs. H. D. Allen, Jr., Milledgeville; C. C. Aven, Atlanta; John S. Atwater, Atlanta; John J. Barnes, Atlanta; Arthur N. Berry, Columbus; Belford C. Blaine, Atlanta; Edgar Boling, Atlanta; R. H. Bradley, Chatsworth; Edmund A. Brannen, Macon; Charles T. Brown, Jr., Guyton; Robert Brown, Atlanta; Stephen W. Brown, Augusta; Frank W. Buckner, Atlanta; James H. Byram, Atlanta; Hugh B. Cason, Warrenton; Peter J. Cline, Atlanta; O. S. Cofer, Atlanta; R. W. Coonrad, Warm Springs; Joe S. Cruise, Atlanta; Howard C. Derrick, Jr., LaFayette; Lovick E. Dickey, Jr., Warner Robins; Charles E. Dowman, Atlanta.

Drs. Cordelia K. Dowman, Atlanta; Edgar M. Dunstan, Decatur; W. G. Elliott, Cuthbert; B. W. Forester, Macon; James R. Garner, Atlanta; Robert B. Greenblatt, Augusta; Hugh H. Gregory, Atlanta; Harvey E. Griggs, Conyers; Henry C. Jackson, Manchester; James B. Kay, Byron; O. Fulton Keen, Macon; D. C. Kelley, Lawrenceville; J. L. King, Macon; Mason I. Lowance, Atlanta; Harold P. McDonald, Atlanta; H. E. Nieburgs, Augusta; A. M. Phillips, Macon; Roy Pope, Jr., Chickamauga; Morgan B. Raiford, Atlanta; Joseph L. Rankin, Atlanta; J. A. Redfearn, Albany; William A. Selman, Atlanta; L. E. Starr, Atlanta; John W. Turner, Atlanta; Elkin Vogt, Lithonia; Robert D. Walter, Calhoun; L. W. Williams, Savannah; L. W. Willis, Bainbridge.

Drs. T. J. Busey, Fayetteville; Albert R. Bush, Hawkinsville; William L. Dobes, Atlanta; Major F. Fowler, Atlanta; Thomas Schley Gatewood, Americus; Wallace M. Gibson, Milledgeville; William Howard Hailey, Atlanta; Harold Jarrell, Macon; J. H. Kite, Decatur; J. C. McDougall, Atlanta; William C. McGeary, Madison; R. C. Pendergrass, Americus; Abraham S. Velkoff, Atlanta; Robert D. Waller, Milledgeville, and L. W. Willis, Bainbridge.

Twenty-five Georgia surgeons were made Fellows of the AMERICAN COLLEGE OF SURGEONS during the special convocation exercises held on November 9 at the Clinical Congress in San Francisco. Dr. Enoch Callaway is chairman of the College's counseling committee for Georgia. The next Clinical Congress will be held in New York City during the week of Sept. 21, 1952.

Georgians named as Fellows are as follows: Drs. John T. Akin, Jr., Atlanta; J. Mason Baird, Atlanta; John L. Chandler, Jr., Augusta; Charles T. Cowart, LaGrange; Robert G. Ellison, Augusta; Edgar F. Fincher, Emory University; William H. Grimes, Jr., Atlanta; Allen E. Hauck, Atlanta; Henry D. Holliman, Jr., Atlanta; William A. Hopkins, Emory University; Alfred E. James, Albany; Gordon M. Kelly, Augusta; William P. Leonard, Atlanta; John William McLeod, Jr., Moultrie; George A. Niles, Jr., Atlanta; Paul L. Rieth, Emory University; Peter L. Scardino, Savannah; Robert H. Stephenson, Atlanta; Calvin B. Stewart, Atlanta; Lawson Thornton, Atlanta; John B. Varner, Atlanta; Hoke Wammock, Augusta; Samuel A. Wilkins, Jr., Emory University; J. P. Woodhall, Macon; Edward S. Wright, Atlanta.

The PRACTICAL NURSES ASSOCIATION OF GEORGIA held a convention in Atlanta on November 7-8, the theme of which was "Education of Practical Nurses." Speakers at the second-anniversary banquet of the organization on November 7 were: Miss Dana Hudson, president of the Georgia State Nurses Association; Mrs. Nora K. Sykes, Augusta, state president of the practical nurses' association, and Dr. Walter W. Daniel, Atlanta. Dr. Daniel discussed the practical nursing bill prepared for introduction at the next session of the Georgia General Assembly—a bill which would provide for the licensing and training of such nurses.

PERSONALS

Transition

DR. T. LUTHER BYRD and DR. FRANKLIN H. GOODWIN announce their association in the practice of internal medicine, Suite 415, Doctors Building, Atlanta.

DR. ROBERT B. CRICHTON in November resigned his post on the medical staff of Milledgeville State Hospital and moved to St. Simons Island.

DR. E. WAYNE CULBRETH announces his association with DR. JAMES B. MARTIN in the practice of medicine and surgery, Martin Clinic, Edison.

DR. A. D. DUGGAN, Washington, in November established an office in Crawfordville, where he will keep office hours on Wednesdays and Saturdays. He is occupying the space formerly used by the late Dr. Alex H. Beazley, and offered to him by Mrs. Beazley.

DR. E. G. EDWARDS has been named orthopedic surgeon for the Central of Georgia Railroad in Savannah. This appointment was announced in November by DR. C. F. HOLTON, chief surgeon for the railroad. Other medical appointments made at the same time were: DR. WILLIAM L. PAULLIN, JR., as assistant company physician in

Atlanta; DR. WILLIAM G. CHAMBLESS, as company surgeon at Hamilton, and DR. MIRIAM W. CHAMBLESS, his wife, as his assistant.

DR. HARRIET E. GILLETTE announces the opening of the Physical Medicine and Rehabilitation Clinic at 73 Eleventh St., N. E., Atlanta.

DR. MAYES GOBER, Marietta surgeon and obstetrician, announces that he will restrict his practice to obstetrics.

DR. IVEY E. HALL, JR., formerly of Macon, has entered the general practice of medicine in Clayton.

DR. IRA B. HARRISON, who has been in Korea on duty with the Army Medical Corps, has been released with the rank of major and is now a resident in medicine at Emory University Hospital.

DR. LAWSON JOHNSON, a graduate of the Medical College of Georgia, has joined his father and brother, DRs. JAMES A. JOHNSON, SR., and JAMES A. JOHNSON, JR., in the general practice of medicine in Manchester.

DR. L. H. MUSE and DR. JULIAN Q. WATTERS announce the removal of their offices to 1102 West Peachtree St., Atlanta.

DR. J. DEAN PASCHAL has opened offices at 717 North Monroe St., Albany. Practice limited to diseases of children.

DR. JOHN PAUL PUCKETT has opened an office at Brooks Hospital, Blue Ridge, for the practice of medicine and surgery.

DR. C. J. RILEY, retired, has returned to Thomasville, where he lived until 12 years ago, and will live there most of the year while maintaining his winter home at Eustis, Fla.

DR. DAVID E. TANNER, who until recently was an officer in the Air Force Medical Corps, has opened offices in the Watkins Building, Sparta.

DR. NEAL FRANKLIN YEOMANS, former resident radiologist of the University Hospital, Augusta, has opened offices for private practice at 229 Bunn Building, Waycross, and had been appointed radiologist on the staff of the Ware County Hospital. He is also acting director of the Waycross Cancer Clinic.

Helpmeets

DR. FREEMAN H. CARY and Mrs. Ruby Samples Smith, both of Atlanta, married on July 26. Dr. Cary is an assistant resident at Grady Hospital.

DR. PERRY GOLD, Atlanta, and Miss Carolyn Goodman, Athens—engaged to be married in December.

DR. ALFRED HINTON HUNT, of Atlanta and Camak, and Miss Patricia Ann Wheeler, of Augusta and Warrenton—married in Augusta on October 1.

DR. SOPHIE CHARLOTTE NEUBERG and DR. JOSEPH T. STUKES, JR., both of Macon—married in Sylvester on October 20.

For Your Admiration

David, son of DR. AND MRS. WILLIAM J. PENDERGRAST, of Atlanta, born October 24.

Bruce Rice, son of DR. AND MRS. THOMAS C. MCPHERSON, of Atlanta, born October 12.

Bill Douglas, son of DR. AND MRS. HENRY D. HOLIMAN, JR., of Atlanta, born September 13.

MISCELLANY

DR. OLIN S. COFER, Atlanta, was elected a member of the executive committee of the Southern Medical Association at its recent convention in Dallas, Tex.

DR. ALFRED COLQUITT, Marietta, has been admitted to membership in the Southeastern Surgical Congress.

DR. J. A. CORRY, Barnesville, accompanied by Mrs. Corry, left last month for New York City, where Dr. Corry plans to study and observe new methods in hospitals and medical centers.

DR. GEORGE DILLARD, the first resident physician in Palmetto in several years, was honored by the Palmetto Better Home Town Club at a banquet in the Community Building in October. Gifts were presented to Dr. and Mrs. Dillard.

DR. BENJAMIN PIERCE GILBERT, Gainesville, last month was elected a Fellow of the American Academy of Pediatrics.

DR. R. C. GOOLSBY, Forsyth, who retired several years ago, observed his 89th birthday anniversary on November 8.

DR. CLAIR A. HENDERSON, Savannah-Chatham County health commissioner, has been appointed chairman for the 1952 March of Dimes for the 15th Georgia polio district.

DR. W. L. HUTCHINSON, LaGrange, recently began a year's special study in obstetrics and gynecology at the University Hospital, Augusta. He plans to return to LaGrange after he completes his work in Augusta.

DR. WILLIAM McMATH, Americus eye-ear-nose-throat specialist, has been certified by the American Board of Ophthalmology.

DR. JOHN W. MAULDIN, Alma, recently completed a postgraduate five-week course in anesthesia and bronchoscopy in Chicago.

The first annual JAMES E. PAULLIN Memorial Lecture, honoring the late Dr. Paullin, was given at Emory University Hospital Auditorium on November 8 by Dr. Russell L. Cecil, New York, noted medical author and professor emeritus of medicine at Cornell University Medical College.

DR. J. M. SMITH, Cochran, celebrated his 76th birthday anniversary on October 15. The following day, he and Mrs. Smith celebrated their 53rd wedding anniversary.

DR. JACK GUY STANDIFER, Blakely, in late October was elected Most Worshipful Grand Master of the Grand Lodge of Georgia Masons.

DR. L. G. STEWART, retired Ellaville physician, observed his 80th birthday anniversary on October 26.

DR. ERNEST THOMPSON, Monroe, Walton County health commissioner, is author of "RFD for Babies," which appears in the October *Progressive Farmer*. The article describes the county's plan for prenatal care of expectant mothers and the low-cost hospital service available there in obstetrical cases.

DR. CALVIN WEAVER, Atlanta, chairman of the history committee of the Medical Association of Georgia, read a paper entitled "Thomas Holley Chivers, Doctor-Poet" at the October meeting of the DeKalb Historical Society, Decatur.

The PHYSICIANS SERVICE ASSOCIATION OF SAVANNAH, which on October 1 began accepting applications for a contract to cover surgical benefits, paid out its first claim that same month. More than 1,000 applications for the service were received in the first three weeks of the Association's existence.

The annual Columbus banquet-meeting of industrial nurses and management was held at the Ralston Hotel, Columbus, on November 2. Principal speakers were Dr. J. M. Bosworth and Miss Josephine Kinnman, both of the Georgia Department of Public Health; Miss Doris Griggs, industrial nurse consultant of Liberty Mutual Life Insurance Company, and Herbert Lec. This annual meeting was sponsored by the Tom Huston Company; representatives of four other major Columbus-area industries attended.

DR. JOHN S. ATWATER, Atlanta, was elected secretary of the Gastroenterology Section of the Southern Medical Association at its annual meeting in Dallas, Tex. on November 5-8. During the week of November 12 he was guest lecturer in gastroenterology at the Postgraduate School of the

Tulane Medical School. His lectures were on "Differential Diagnosis of Regional Enteritis and Steatorrheic Diseases," "Chronic Ulcerative Colitis" and "Gastroscoy in the Diagnosis of Stomach Lesions." In connection with the third lecture, Dr. Atwater showed a motion picture in color made by him on the use of anesthetics in gastroscopy.

DR. L. P. HOLMES, Augusta, recently was appointed a councilor in the American College of Radiology by its Board of Chancellors in annual session at Washington, D. C.

DEATHS

ADAMS: *Dr. Charlie Adams*, 51, Cordele physician and surgeon and owner of the Adams Hospital there, died November 2 following a heart attack. Formerly a member of the Cordele City Commission, past president of the Crisp County Chamber of Commerce, past president of the Cordele Touchdown Club.

BAKER: *Dr. Luther P. Baker*, 69, Atlanta physician for 42 years, died November 13. Born in Campbell County, he moved to Atlanta as a youth. Was 1909 graduate of Atlanta's Hospital Medical College, Eclectic, now extinct; also took work in Chicago. For four years represented the Sixth Ward in Atlanta City Council. Was past master of Capital City Blue Lodge.

MALLOY: *Dr. Daniel William Franklin Maloy*, 61, of Milan, died October 31 of a heart ailment, after an illness of several weeks. A native of Telfair County, he had practiced in Milan for many years.

MULLINS: *Dr. Glenn Mullins*, 59, a member of the staff of the Veterans Administration Hospital, Dublin, since 1948, died November 4 of a heart attack. Born in Douglas County, he was graduated from the Emory University School of Medicine in 1915. Postgraduate work at Yale University and Mt. Pelier University, France. Veteran of World War I and II and held the Reserve rank of lieutenant colonel. Had been with the Veterans Administration since 1925, and at one time was stationed in Atlanta.

MEDICAL SCHOOLS

Deans of the state's two medical schools—Dr. R. Hugh Wood, Emory University School of Medicine, and Dr. G. Lombard Kelly, Medical College of Georgia—attended the 62nd annual meeting of the Association of American Medical Colleges at French Lick Springs, Ind., October 29-31. Dr. Wood served as chairman of the committee on Veterans Administration-medical school relationships.

PRESIDENT REAVIS

We learn with sincere regret of the painful accident that befell President Reavis in late November, which has confined him to his home for several weeks. Then on December 2 his daughter, Mrs. Frank Pugh, died suddenly at her home in Atlanta. Our sympathies go to him and Mrs. Reavis in this hour of sorrow and sadness.

HOSPITALS

Dr. Wadley Glenn, Atlanta medical director of Atlanta's CRAWFORD LONG HOSPITAL, on November 1 joined the department of surgery at GRADY MEMORIAL HOSPITAL on a part-time basis. He will continue to serve as medical director at Crawford Long.

Albany's PHOEBE PUTNEY MEMORIAL HOSPITAL is sponsoring a series of radio programs produced and transcribed by the American Hospital Association and called "At Your Service." The first of the 13 quarter-hour shows was aired over radio station WALB on November 4, and others in the series have been presented at weekly intervals since that time.

Members of the MCDUFFIE COUNTY HOSPITAL staff, Thomson, have elected as their officers Dr. F. N. Gibson, president, and Dr. Albert G. Leroy, secretary.

BOOKS RECEIVED

TEXTBOOK OF REFRACTION: By Edwin Forbes Tait, M.D., Ph.D., Associate Professor of Ophthalmology, Temple University School of Medicine; Attending Surgeon (Ophthalmology), Temple University and Montgomery Hospitals. 418 pages with 93 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price \$8.00.

PHYSICAL MEDICINE AND REHABILITATION FOR THE CLINICIAN: Edited by Frank H. Krusen, M.D. 371 pages with 96 figures and 13 tables. Philadelphia and London: W. B. Saunders Company, 1951. Price \$6.50.

SURGICAL PRACTICE OF THE LAHEY CLINIC: by Members of the Staff of Lahey Clinic, Boston. 1014 pages, 784 illustrations on 509 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price \$15.00.

